KY Department for Public Health

Kentucky HIV/AIDS Strategy

2012

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Executive Summary

The State of Kentucky is committed to reducing rates of HIV infection, providing compassionate, comprehensive care to individuals living with HIV/AIDS, and to combating stigma and health disparities which have fostered a climate where HIV cannot be openly addressed. This document highlights the commitment of the Kentucky Department for Public Health to reduce disparities, to improve high-impact HIV prevention activity, and to address gaps in services for Kentuckians living with HIV/AIDS.

Designed to be aligned with the National HIV/AIDS Strategy, the *Kentucky HIV/AIDS Strategy* details the efforts of the HIV/AIDS Branch to develop a comprehensive prevention and care strategy to record and address unmet needs in Kentucky. Additionally, every attempt has been made to make certain that this document addresses the priorities established in the *Early Identification of Individuals with HIV/AIDS* (EIIHA) guidance and the *Healthy People 2020* recommendations. Further, this document has been crafted using the *CDC Guidance on HIV Prevention Planning* and the *HRSA SCSN and Comprehensive Plan* guidance, while aligning strategies with the relevant statutes in the *Patient Protection and Affordable Care Act* (PPACA).

Like much of the United States, Kentucky has seen a leveling off of new HIV/AIDS cases, but the level of infections remains unacceptable. HIV prevention efforts, clearly successful in reaching many at risk individuals, must be scaled up to have the broadest impact in communities at risk for HIV. Compassionate state-of-the-art HIV care is being delivered in health care facilities throughout Kentucky, but the gaps in available services and geographic constraints remain daunting challenges for the Ryan White Program. Finally, our efforts to reduce impact of HIV-related stigma and health disparities must be re-doubled as we endeavor to reduce new infections and to enhance care to those individuals in Kentucky living with HIV/AIDS.

This document represents a collaborative endeavor that engaged more than five hundred Kentuckians in its creation. Stakeholders from all Ryan White Parts in the state were represented, as were consumers, prevention providers, administrators, and concerned community partners. A series of activities to gather input were conducted in early 2012 which have greatly impacted the scope and emphasis of this document. This assessment process led into a planning process where members of the HIV/AIDS

Branch created a comprehensive plan to prevent HIV and to respond to the unmet needs of individuals living with HIV/AIDS. It is dedicated to individuals living with HIV/AIDS in Kentucky and to individuals at highest risk; we know our work is not done and we pledge to continue until there is a cure.

Introduction

This document has been created to showcase a comprehensive approach to HIV in Kentucky. It is designed both to inform Kentuckians about the strategy, but also to fulfill the requirements of the Health Resources and Services Administration [HRSA] and the U.S. Centers for Disease Control and Prevention [CDC] in continuing funding to address the gaps in prevention services and care that exist.

A comprehensive assessment of prevention and care services has been conducted in preparing this document. A wide range of stakeholders were asked about: (1) gaps in prevention and care services, (2) prioritized sense of unmet need, (3) issues for individuals unaware of their status, and (4) suggestions for enhancing linkage to care for those newly diagnosed and retention in care for those most vulnerable individuals living with HIV/AIDS.

This effort has coincided with the creation of the latest HIV/AIDS surveillance report which describes the epidemic in Kentucky—both successes and challenges. An analysis of this document—including identification of populations most impacted and an analysis of the structural and broader health issues will be reported.

Finally, the 'heart' of this document is a comprehensive plan—a set of goals and objectives—designed to enhance how both *HIV prevention* and *HIV care services* are delivered in Kentucky. In addition to a plan, a description of the strategies to monitor and evaluate the plan, a discussion of quality improvement activities, and plans for capacity-building for internal and external partners is presented.

Jurisdictional HIV Prevention Plan Narrative

HIV prevention in Kentucky takes place in a range of traditional and non-traditional settings as seen in the section titled, *Description of Existing Resources*. The various elements of the Jurisdictional HIV Prevention Plan, existing resources, needs, and gaps for HIV prevention services- including key features on how prevention services, interventions, and/or strategies are currently being used or delivered, determination of the populations at greatest risk for HIV, individuals who are unaware of their HIV positive status, a comprehensive understanding of prevention services in the jurisdiction, a consideration of all available resources, epidemiological data, existing quantitative and qualitative information, and emerging trends/issues affecting HIV prevention services, are provided through various sections of this strategy document.

Disease Burden in KY

As of December 31, 2010, a cumulative total of 5,246 cases of HIV infection, regardless of the stage of disease at diagnosis, have been reported among Kentucky residents. Of these cases, 2,500 people were living with the HIV infection through the end of 2010. There were a total of 2,004 males (80%) and 496 females (20%) diagnosed with HIV infection (not AIDS) while there were a total of 2,253 (82%) and 493 females (18%) with AIDS.

Additionally, this section includes the following information:

- Epidemiological Profile Table of HIV (Not AIDS) Prevalence and AIDS Prevalence by Demographic Group and Exposure Category
- Kentucky HIV Epidemiologic Profile as of June 31, 2011
- Comparative description of the number of people living with HIV (non-AIDS) over the past two calendar years
- The number of people living with AIDS

- The number of new AIDS cases reported within the last two calendar years (01/01/09 – 12/31/10)
- Kentucky Unmet Needs Framework, 2010
- Kentucky Early Identification of Individuals with HIV/AIDS (EIIHA) Matrix
- Estimate of Number of Kentuckians Living with HIV Infection who were Unaware of their Status as of December 31, 2009
- Behavioral Profile of Newly Diagnosed HIV Infections among Kentuckians within the Most Recent 5 Year Period (2006-2010)

HIV (Not AIDS) Prevalence and AIDS Prevalence by Demographic Group and Exposure Category

Demographic Group/ Exposure Category	HIV (NOT AIDS) PREVALENCE THROUGH DEC 31, 2010 HIV (NOT AIDS) *Prevalence is defined as the number of people living with HIV as of the date specified.*		AIDS PREVALENCE THROUGH DEC 31, 2010 *AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.*	
Race/Ethnicity	**Number**	**% of Total**	**Number**	**% of Total**
White, not Hispanic	1,444	58%	1,675	61%
Black, not Hispanic	937	37%	876	32%
Hispanic	84	3%	161	6%
Other	35	2%	34	1%
Total	**2,500**	**100%**	**2,746**	**100%**
Sex	**Number**	**% of Total**	**Number**	**% of Total**
Male	2,004	80%	2,253	82%
Female	496	20%	493	18%
Total	**2,500**	**100%**	**2,746**	**100%**
Age at Diagnosis (Years)	**Number**	**% of Total**	**Number**	**% of Total**
<13 years	26	1%	28	1%
13 - 19 years	168	7%	70	3%
20 - 29 years	894	36%	746	27%
30 - 39 years	779	31%	1,048	38%
40 - 49 years	474	19%	626	23%
50+ years	159	6%	228	8%
Total	**2,500**	**100%**	**2,746**	**100%**

Demographic Group/ Exposure Category	HIV (NOT AIDS) PREVALENCE THROUGH DEC 31, 2010 HIV (NOT AIDS) *Prevalence is defined as the number of people living with HIV as of the date specified.*		AIDS PREVALENCE THROUGH DEC 31, 2010 *AIDS Prevalence is defined as the number of people living with AIDS as of the date specified.*	
Adult/Adolescent Exposure Category	**Number**	***% of Total***	**Number**	***% of Total***
Men who have sex with men	1,289	52%	1,452	53%
Injection drug users	160	6%	304	11%
Men who have sex with men and inject drugs	87	3%	145	5%
Heterosexual	310	12%	499	18%
Other/Hemophilia/Blood Transfusion/Transplant	2	<1%	16	1%
Risk not reported or identified	626	25%	302	11%
Subtotal	**2,474**	**100%**	**2,718**	**100%**
Pediatric Exposure Categories	**Number**	***% of Total***	**Number**	***% of Total***
Perinatal exposure, mother with HIV	23	88%	23	82%
Pediatric Hemophilia	-	-	5	18%
Pediatric no risk reported	3	12%	-	-
Subtotal	**26**	**100%**	**28**	**100%**

Data Sources:

Data were obtained from the Kentucky Department for Public Health, HIV/AIDS Branch, via the enhanced HIV/AIDS Reporting System (eHARS) database.

Data are current as of June 30, 2011; include Kentuckians diagnosed and living by December 31, 2010, regardless of current residence.

Reporting delays exist for all data, especially in more recent years.

Percentages may not total 100% due to rounding.

Comparative description of the number of people living with HIV (non-AIDS) over the past two calendar years

At the end of 2009, there were 2,287 living HIV (non-AIDS) infections among Kentuckians reported to the Department for Public Health, compared to 2,500 living HIV (non-AIDS) cases at the end of 2010. This represents an increase of 9.3%. The distribution of HIV (non-AIDS) infections by sex is comparable, with the majority of living cases diagnosed among males: 80% for both years.

By current age as of June 30, 2011, the distribution of living HIV cases was also similar, with almost half of living cases for both years (48%) aged 25-44 years. Persons aged 45-64 years accounted for the second highest percentage of living HIV cases for both years (43% in 2009 and 41% in 2010). Children (less than 13 years old) and persons aged 65+ years accounted for the smallest percentage of living cases for both years at less than 5% each.

By exposure category, Men who have Sex with Men (MSM) accounted for the majority of living cases consecutively (52% each year). Persons reporting heterosexual contact with a person with HIV or at risk for HIV accounted for about 13% of living cases each year. The proportion of living cases reporting Injection drug use (IDU), MSM/IDU and other modes of transmission are comparable across the 2 year period. Additionally for both years, about a quarter of living cases were reported with no risk factor identified.

Data by race/ethnicity over the last two year period show the majority of living cases (about 58% each year) were diagnosed among White (non-Hispanics). Black (non-Hispanics) accounted for about 37% and Hispanics for about 3% of living cases each year. Persons of other races including American Indians/ Alaskan Natives, Native Hawaiian/ Pacific Islanders and persons of multiple races accounted for less than 2% of living cases for each of the last two years. There were slightly more black females living with HIV at the end of both 2009 and 2010, compared with white females (47% vs. 46% in 2009 and 47% vs. 45% in 2010, respectively). Among males however, higher percentages of white males were living with HIV in comparison to their black counterparts (44% vs. 34% in 2009 and 45% vs. 35% in 2010 respectively).

The number of people living with AIDS

At the end of 2009, there were 2,670 living AIDS infections among Kentuckians reported to the Department for Public Health, compared to 2,746 living AIDS cases at

the end of 2010. This represents an increase of 2.8%. The distribution of AIDS cases by sex is comparable, with the majority of living cases diagnosed among males: 82% for both years.

By current age as of June 30, 2011, the distribution of living AIDS cases was also similar, with over half of living cases for both years (about 58%) aged 45-64 years. Persons aged 25-44 years accounted for the second highest percentage of living AIDS cases for both years (36% in 2009 and 37% in 2010). Children (less than 13 years old) and persons aged 65+ years accounted for the smallest percentage of living cases for both years at less than 5% each.

By exposure category, Men who have Sex with Men (MSM) accounted for the majority of living AIDS cases consecutively (53% each year). Persons reporting heterosexual contact with a person with HIV or at risk for HIV accounted for about 18% of living cases each year. The proportion of living cases reporting Injection drug use (IDU), MSM/IDU and other modes of transmission are comparable across the 2 year period. Additionally for both years, a tenth of living cases were reported with no risk factor identified. This is lower than that of persons living with HIV (non-AIDS).

Data by race/ethnicity over the last two year period shows the majority (61% each) of living AIDS cases were diagnosed among White (non-Hispanics). Black (non-Hispanics) accounted for 32% and Hispanics for about 6% of living cases each year. Persons of other races including American Indians/ Alaskan Natives, Native Hawaiian/ Pacific Islanders and persons of multiple races accounted for less than 2% of living cases for each of the last two years. There were slightly more black females living with AIDS at the end of both 2009 and 2010, compared with white females (49% vs. 44% in 2009 and 49% vs. 43% in 2010 respectively). Among males however, higher percentages of white males were living with AIDS in comparison to their black counterparts (65% vs. 28% in both 2009 and 2010 respectively).

The number of new AIDS cases reported within the last two calendar years (01/01/09-12/31/10)

The trend for the last two calendar years (2009 and 2010) shows a similar number of newly diagnosed AIDS cases among Kentuckians reported to the Department for Public Health. As of June 30, 2011, there were 170 Kentuckians who had newly progressed to AIDS for each of the two calendar years. These numbers of new AIDS cases are lower than the previous two years (226 in 2007 and 235 in 2008), indicating either reporting delays or better access to care which delayed progression to AIDS in the most recent

two years. The distribution of AIDS cases by sex is comparable, with the majority of cases diagnosed among males: 81% in 2009 and 79% in 2010.

By age at time of AIDS diagnosis, the highest number of cases in 2009 were aged 40-49 years at time of diagnosis (59 new cases), whereas in 2010, 52 (31%) new cases were aged 30-39 years at diagnosis. Teenagers accounted for the smallest percentage of new AIDS cases for both years at less than 2% each, and there were no new pediatric AIDS cases reported for the last 2 years.

By exposure category, Men who have Sex with Men (MSM) accounted for the majority of AIDS cases consecutively (about 47% each year). Persons reporting heterosexual contact with a person with HIV or at risk for HIV accounted for about 12% of new AIDS cases each year. The proportions of AIDS cases reporting Injection drug use (IDU) and MSM/IDU were slightly higher among persons diagnosed in 2009, compared to those diagnosed in 2010. Eight percent of IDUs were newly diagnosed in 2009 compared to 5% in 2010 and 4% of MSM/IDUs were newly diagnosed in 2009 compared to 1% in 2010. There were more new cases in 2010 reported with no risk factor identified (35%), compared to 30% in 2009.

Data by race/ethnicity for 2009 shows the majority (60%) of new AIDS cases were diagnosed among White (non-Hispanics). Black (non-Hispanics) accounted for 32% and Hispanics for 6% of new AIDS cases. Persons of other races including American Indians/ Alaskan Natives, Native Hawaiian/ Pacific Islanders and persons of multiple races accounted for less than 2% of new AIDS cases in 2009. In 2010, the highest percentage of new AIDS cases were White (48%), but it was less than the percentage of whites diagnosed in 2009. Blacks and Hispanics also accounted for higher percentages of new AIDS cases in 2010 compared to 2009: 37% blacks and 12% Hispanics.

There were slightly more black females newly diagnosed with AIDS in 2010 (20 cases) compared to 2009 (14 cases). Among white females, more AIDS cases were newly diagnosed in 2009 (17 cases) compared to 2010 (10 cases). There was 1 new female Hispanic AIDS case in 2009 and 4 in 2010. Among males however, higher numbers of white males were newly diagnosed with AIDS in both consecutive years, in comparison to their black and Hispanic counterparts.

Kentucky Unmet Need Framework, 2010

Population Sizes		Value		Data Source(s)
Row A	PLWA[1]	2,697		Enhanced HIV/AIDS Reporting System (eHARS)
Row B	PLWH[2], non-AIDS	2,435		Enhanced HIV/AIDS Reporting System (eHARS)
Row C	Total PLWH/A[3]	5,132		Enhanced HIV/AIDS Reporting System (eHARS)
	Care Patterns	**Value**		**Data Source(s)**
Row D	Number of PLWA who received HIV primary medical care during the 12-month period January 1, 2010-December 31, 2010	1,892		eHARS database, Ryan White Part B Program and Medicaid data. Number of persons living with AIDS who had a viral load assay and/or a CD4+ assay in eHARS, care through the Ryan White Part B Program, or care through Medicaid in the 12 month period.
Row E	Number of PLWH/non-AIDS who received the specified HIV primary medical care during the 12-month period January 1, 2010 - December 31, 2010	1,269		eHARS database, Ryan White Part B Program and Medicaid data. Number of persons living with AIDS who had a viral load assay and/or a CD4+ assay in eHARS, care through the Ryan White Part B Program, or care through Medicaid in the 12 month period.
Row F	Total number of HIV+ who received the specified HIV primary medical care during the 12-month period January 1, 2010 - December 31, 2010	3,161		eHARS database, Ryan White Part B Program and Medicaid data. Number of persons living with AIDS who had a viral load assay and/or a CD4+ assay in eHARS, care through the Ryan White Part B Program, or care through Medicaid in the 12 month period.
	Calculated Results	**Value**	**%**	**Calculation**
Row G	Number of PLWA who did not receive the specified HIV primary medical care	805	30	Value = A - D Percent = G/A

Row H	Number of PLWH/non-AIDS who did not receive the specified HIV primary medical care	1,166	48	Value: B - E Percent: H/B
Row I	Total HIV+ not receiving the specified HIV primary medical care (quantified estimate of unmet need)	1,971	38	Value: G + H Percent: I/C

[1] Persons living with AIDS, who had a Kentucky residence at time of HIV diagnosis.
[2] Persons living with HIV- not AIDS, who had a Kentucky residence at time of HIV diagnosis.
[3] Persons living with HIV and/or AIDS, who had a Kentucky residence at time of HIV diagnosis.
Data are current as of December 31, 2011, therefore not similar to data presented in the epidemiologic profile. These tables compare persons living with HIV and/or AIDS with met needs to those with unmet needs through eHARS Database, Ryan White Part B Program data and Medicaid data.

Unmet Need Narrative

Process for updating the unmet need estimate

The estimate of persons living with HIV disease in Kentucky is updated at the beginning of every calendar year through data linkages between HIV surveillance data from *enhanced HIV/AIDS Reporting System (*eHARS) and data from the Ryan White Part B Program and Medicaid, using the methodology described below. The most current estimate available is of persons living with HIV at the end of 2010 who had unmet need.

Data Sources and Estimation Methods Used:

The following methodology was used to estimate unmet need in 2010 for HIV-related primary care for persons living in Kentucky at time of HIV diagnosis.

First: Definition of Care:

"Care" was defined as having a laboratory result within the 12 month period January 1, 2010, through December 31, 2010, assessed at 12 months after the reporting period to account for reporting delays, or care provided through the Ryan White program or Medicaid program. Test results included a viral load assay and/or CD4+ assay among persons in eHARS. Use of anti-retroviral therapy (HAART) was not included in the definition of care because HIV Surveillance does not collect this information routinely. However, it is believed that majority of patients on HAART regularly have CD4 and/or

viral load tests to measure efficacy. Therefore, the number of patients in care who are missed using laboratory data alone is expected to be minimal.

Second: Three databases were utilized, with cross program collaboration:

i. *The enhanced HIV/AIDS Reporting System* (eHARS). eHARS is the surveillance database that contains information on reported HIV infections and AIDS cases in Kentucky. Cases entered in eHARS were either diagnosed in the Commonwealth of Kentucky or have resided in the state since being diagnosed. eHARS contains population-based data needed to determine the population of HIV-infected persons and their demographic distribution. Mandatory laboratory reporting in Kentucky exists for all HIV positive tests including Elisa, Western blot, PCR, HIV antigen or HIV culture, absolute CD4+ cells and CD4%, HIV detectable viral load assays, positive serologic test results for HIV infection and a diagnosis of AIDS that meets the definition established within CDC guidelines. These laboratory results are imported into eHARS routinely and maintained by the HIV Surveillance program.

ii. *CAREWare database.* CAREWare is free, scalable software used to manage and monitor HIV clinical and supportive care within the Ryan White part B program. It houses data from the Kentucky HIV/AIDS Care Coordination Program (KHCCP) that tracks demographics and client utilization of the core and supportive services through the Ryan White part B program as well as Kentucky AIDS Drug Assistance Program (KADAP) data.

iii. *The Medicaid database.* Medicaid is a state administered program available only to those low-income individuals and families who fit into an eligibility group that is defined by federal and state law. Certain requirements that must be met include age, pregnancy, disability, blindness, personal income and resources (like bank accounts, real property, or other items that can be sold for cash), and U.S. citizenship or a lawful immigrant status. Additional information available at: http://www.cms.hhs.gov/MedicaidGenInfo/

Third: Methodology and Population Estimates:

I. Laboratory data in eHARS were used to determine whether or not each person diagnosed with HIV disease as of December 31, 2010, had a viral load assay, or CD4+ assay collected in the calendar year 2010. These eHARS data were then analyzed for cases living by December 31, 2010, with residence at time of HIV infection in Kentucky. Kentucky cases in eHARS *without* a laboratory test done in 2010 were then matched with data from the Ryan White Part B Program, and Medicaid data. Persons diagnosed after December 31, 2010 were excluded from analysis. Data were assessed 12 months after the reporting period to account for reporting delays among persons who were diagnosed closer to the end of 2010 and had not yet established care.

II. Ryan White Part B Care Coordinator Program data were used to further determine Kentucky cases in eHARS who had no record of laboratory tests collected in 2010, but who received HIV related primary care through the Part B Program. All eligible cases with no laboratory tests in eHARS were matched against CAREWare to confirm whether or not they had received care in the mentioned time period.

III. Medicaid data were used in the final analysis to determine Kentucky cases in eHARS who had no record of laboratory tests collected in 2010 and had not received care through the Ryan White Part B Care Coordinator Program, but received medical attention through Medicaid services and were classified as having any one of the following International Classifications of Disease (ICD-9CM codes- 2008 book) for HIV infection: 042- HIV disease, V08- asymptomatic HIV infection status, V01.79- exposure to HIV virus and 795.71- nonspecific serologic evidence of HIV. Persons with lab procedures related to HIV disease were also considered as having met need, including Current Procedural Terminology (CPT) codes: 86701 HIV-1, 86702 HIV-2, 86703 HIV-1 and HIV-2 single assay, 87390 HIV-1 antigen, 87391 HIV-2 antigen, and 86689 Western Blot.

Population Estimate: Unmet need was calculated by determining the number of living persons in eHARS who were diagnosed as of December 31, 2010, lived in Kentucky at the time of HIV diagnosis, did not have a laboratory result collected in 2010 reported to the surveillance office by December 31, 2011, and were not enrolled in Medicaid services in 2010 or in the Kentucky HIV/AIDS Care Coordination Program (KHCCP).

Limitations:

While the combination of surveillance, Ryan White Part B and Medicaid data offers a suitable way to measure unmet need, there are some limitations to the data that should be noted.

I. The estimate does not account for in and out migration because the surveillance program isn't always notified when people move out of the state. Reports on people who move into Kentucky are mainly received if care is established, therefore presenting a limitation in the ability to identify Kentucky cases being served in other states and out of state cases served in Kentucky. Consequently, since in and out migrations were unaccounted for, this may have slightly adjusted the unmet need estimate due to the mobility of persons receiving care in and out of Kentucky. Similarly, if a person died and the surveillance program was not notified, this person is assumed to be out of care,

although this effect should be small due to annual death ascertainment activities carried out by the program.

II. Although the Framework requests the number of persons who are aware of their status, HIV/AIDS surveillance has not captured HIV status awareness routinely. Thus, the estimates in the Framework include persons who meet the described criteria above, whether aware of their status or not. The numbers in the framework are different than the data presented in the epidemiologic profiles due to different HIV/AIDS diagnosis date restrictions (only persons living and diagnosed with HIV disease by December 31, 2010).

III. Lastly, Kentucky is bordered by seven states and it is common for treatment to be sought at the nearest medical facility, which may be in a neighboring state. Unless the tests are done by a reference laboratory, there is no way to guarantee that all laboratory tests being performed in private institutions are being reported to Kentucky surveillance. However, the surveillance program participates in inter-state de-duplication with other surveillance programs nationwide, with guidance from the CDC, therefore some information on migrant cases is obtained that way.

Assessment of unmet need:

i. Demographic and Regional Analysis of Those Not in Care

The Unmet Need Framework shows that for the time period January 1, 2010-December 31, 2010, there were an estimated 2,435 persons living with HIV (PLWH) and 2,697 persons living with AIDS (PLWHA) for a total of 5,132 persons living with HIV disease (PLWHA).

There were 3,161 (61.5%) persons living with HIV/AIDS (PLWHA) estimated to have been in care during the year 2010. Of these 1,269 (40%) were living with HIV non-AIDS (PLWH) and 1,892 (60%) with AIDS (PLWA).

There were 1,971 (38%) persons living with HIV/AIDS (PLWHA) estimated to be out of care during the year 2010. Of these, 1,166 (59%) were living with HIV non-AIDS (PLWH) and 805 (41%) were living with AIDS (PLWA).

By sex, 83% of the 1,971 PLWHA who were out of care were male and 17% were female.

By race/ethnicity, the majority of PLWHA with unmet need were white, non-Hispanic (52%). Forty one percent were black, non-Hispanic, 6% were Hispanic and about 1% was of other races.

By sex and race/ethnicity, among females, the majority of unmet need cases were black, non-Hispanic females (53%). Thirty eight percent were white, non-Hispanic females and 6% were Hispanic females. Among males however, the majority of unmet need cases were white, non-Hispanic males (55%). Black, non-Hispanic males accounted for 38% of unmet need cases and Hispanic males for 6%.

By current age as of December 31, 2010, unmet need was highest among persons aged 40 years or older. PLWHA in the 40-49 year age group accounted for the highest percentage of unmet need at 36% and those aged 50+ years accounted for 30% of unmet need in 2010. PLWHA in their 30s accounted for 23% of unmet need and those in their 20s for 12%. Pediatric cases and teenagers accounted for less than 1% each of unmet need in 2010.

By age at time of initial HIV diagnosis, unmet need was highest among PLWHA diagnosed while in their 20s (36%) and 30s (33%). PLWHA aged 40-49 years at time of diagnosis accounted for 17% of unmet need and those aged 50+ and teenagers accounted for about 6% each. Pediatric cases had the smallest percentages of unmet need at less than 1%.

By primary mode of transmission, men who have sex with men (MSM) accounted for almost half of PLWHA with unmet need (48%). Twelve percent of PLWHA with unmet need were exposed through heterosexual contact and 7% through injection drug use (IDU). A quarter of PLWHA with unmet need had no risk factor identified and all other modes of exposure accounted for less than 1% each.

Lastly, the pattern of unmet need by geographic region of residence at time of HIV diagnosis for all 1,971 PLWHA is similar to prevalence patterns, with the highest percentages in three particular Area Development Districts (ADDs). Collectively, data show that the majority (56%) of cases with unmet need were living in KIPDA ADD at time of HIV diagnosis, 14% in Bluegrass ADD and 10% in Northern Kentucky ADD. Individually, 5 of the 15 ADDs had an unmet need estimate above the state estimate of 38%, including FIVCO ADD (49 % of 75), KIPDA ADD (43% of 2,521), Lincoln Trail ADD (46% of 163), Northern Kentucky ADD (47% of 422) and Pennyrile ADD (40% of 131). Most of the ADDs had comparable percentages of unmet need and cases diagnosed concurrently with AIDS within 30 days of initial HIV diagnosis, which is a proxy indicator of unmet need.

The pattern of unmet need by care coordinator region is also similar to prevalence patterns, with the majority of unmet need in among residents of Volunteers for America (VOA) region (56%). Residents served by the Bluegrass Care Clinic (BCC) had the second highest percentage of unmet need (17%), followed by residents served by Northern Kentucky District Health Department at 10%. Residents served by Matthew25 AIDS Services accounted for 9% of unmet need, while residents served by Cumberland Valley District Health Department and Heartland Cares Inc. accounted for less than 5% of unmet need in 2010.

ADD means Area Development District. In Kentucky, there are fifteen. Conceptually, they were formed by local elected officials and citizens in the Commonwealth to find collaborative means to deal with problems that beset their communities. For more information about ADDs, visit http://kycadd.org/index.html

ii. Trends associated with the past 5 years regarding Unmet Need

The earliest unmet need estimate for Kentuckians living with HIV/AIDS was calculated for calendar year 2007. Therefore, trends for the years of data available (2007, 2008, 2009 and 2010) will be assessed in this section. It is imperative to note that slightly different methodologies were used to calculate unmet need for each of these calendar years; hence direct comparisons should not be made.

The trend in percentage of persons living with HIV non-AIDS (PLWH) with unmet need increased from 28% in 2007, to 30% in 2008, to 41% in 2009 and 48% in 2010. Conversely, the trend for persons living with AIDS (PLWA) with unmet need reduced from 32% in 2007, to 26% in 2008 and again in 2009 and increased to 30% in 2010. The percentage of PLWHA with unmet need fluctuated from 30% in 2007 to 28% in 2008 to 33% in 2009 and 38% in 2010. These fluctuations are likely a result of Kentucky's HIV data being incomplete until the end of 2008, as a result of name-based HIV reporting having been implemented in late 2004. The increase in the 2010 estimate is more likely a function of surveillance. During 2010, several previously coded cases were resolved and added to the HIV registry, which increased Kentucky's prevalence rates. However, these cases were mostly diagnosed prior to 2004; therefore Kentucky may not have the most up-to-date information on their care due to the mobility of our society.

Trends by sex show that the majority of PLWHA who had unmet need in the most recent four years were male (about 84% for all years). By race/ethnicity, white non-Hispanics accounted for the majority of unmet need cases at 55% in 2007, 53% in 2008 and 2009 and 52% in 2010. Black non- Hispanics accounted for the second highest percentage of persons with unmet need in Kentucky at about 38% between 2007-2009 and 41% in 2010. Hispanics accounted for the smallest percentage of unmet need cases at about 7% each year.

Trends by age at time of HIV diagnosis show that the highest percentage of persons having unmet need were aged 30-39 years old at time of HIV diagnosis at a little over a third for 2007 and 2008. In 2009 and 2010 however, persons aged 20-29 years at time of HIV diagnosis had the highest percentage with unmet need (36%). HIV infected children less than 13 years at time of HIV diagnosis accounted for the lowest percentage of unmet need each year.

By mode of transmission, the trend of persons with unmet need shows the highest percentages among males who reported sexual contact with other males (MSM) at about half of cases for each year. Persons reporting heterosexual contact and those reporting injection drug use (IDU) accounted for about the same proportion of cases with unmet need over the four year period. Persons with no risk factor identified accounted for less than 20% of unmet need in 2007 and 2008, and for almost a quarter of cases in 2009 and 2010.

Lastly, a comparison of trend of unmet need by geographic location at time of HIV diagnosis shows a pattern similar to the distribution of HIV infections in Kentucky. The highest percentages of persons with unmet need were residents of KIPDA Area Development District (ADD), Bluegrass ADD and Northern Kentucky ADD at time of HIV diagnosis. The highest percentages of persons with unmet need were residents served by VOA, BCC and Northern Kentucky District Health Department care coordinator regions.

iii. Comparison of newly diagnosed vs. old diagnoses among PLWHA with unmet need

This section looks at PLWHA with unmet need in Kentucky diagnosed between 1999- through the analysis year (2010). Newly diagnosed cases in 2009 and 2010 are compared with semi-newly diagnosed cases in 2008 and 2007 and with old diagnoses between 2006-1999.

Between 1999 and 2010, there were 1218 PLHWA in Kentucky with unmet need for the calendar year 2010. Of these, 14% were newly diagnosed in the two year period 2009 and 2010, 19% were semi-newly diagnosed in the preceding two year period 2007 and 2008 and 67% were older diagnoses between 2006 and 1999. A comparison of the new and semi-new diagnoses shows that unmet need in 2010 was lower among PLWHA diagnosed closer to the analysis period (14%) than among those diagnosed in the preceding two years (19%) or earlier (67%).

By sex, unmet need was higher among males than females for all three diagnosis groups. Among the 997 males with unmet need in 2010, 15% were newly diagnosed, 19% semi-newly diagnosed and 67% old diagnoses. A similar trend exists among the 221 females with unmet need, with 10%, 20% and 70% new, semi-new and old diagnoses respectively.

By race/ethnicity, 47% of the 1218 PLWHA with unmet need in 2010 were white, 44% black and 7% Hispanic. Among the 167 new cases, the majority were black (53%), compared to 41% of whites. Among the semi-new cases, the highest percentage were also black (45%), compared to 43% whites. There are more whites with unmet need among older diagnoses (49%).

By race/ethnicity and sex, black PLWHA have higher percentages of unmet need within the new and semi-new diagnosis groups. Among females, whites accounted for the majority of unmet need among the 21 new diagnoses at 52%, but blacks accounted for 43%. Among the semi-new female diagnoses (44 cases), blacks accounted for 48%, compared to 41% among whites. Among males, blacks accounted for the majority of the 146 new diagnoses with unmet need (54%), compared to 40% of whites. Among the semi-new male diagnoses (184), blacks accounted for 45% of unmet need, compared to 43% among whites.

By current age as of December 31, 2010, unmet need in 2010 was highest among PLWHA in their 40s (36%), followed by PLHWA aged 50+ years (30%). PLWHA in their 30s accounted for 23% of unmet need, followed by 20-29 year olds (12%). Teens and pediatrics accounted for less than 1% each. Among the 167 new cases, 20-29 year olds accounted for the highest percentage of unmet need (37%). A similar trend exists among semi-new diagnoses, with 20-29 year olds accounting for 34% of unmet need.

By mode of transmission, MSM accounted for the highest percentage of unmet need in 2010 (46%). Twelve percent of PLWHA with unmet need had risk of heterosexual contact, 6% were through IDU and 3% through MSM/IDU. Thirty one percent of cases did not have a risk factor identified. The risk groups within the different diagnosis groups have a similar distribution.

By care coordinator region, the top three regions with the highest percentages of unmet need both collectively and within the three diagnosis groups were residents served by VOA, BCC and Northern Kentucky District Health Department care coordinator regions.

Kentucky Early Identification of Individuals with HIV/AIDS (EIIHA) Matrix

<table>
<tr><td colspan="3">P1. ALL Individuals in Kentucky who are Unaware of their HIV Status (HIV Positive & Negative – Tested & Untested – Publically & Privately Tested)</td></tr>
<tr><td colspan="3">P2. Tested in the Last 12 months</td></tr>
<tr><td colspan="2">P4. Persons not posttest counseled and not given results* (HIV positive & HIV negative)</td><td>T3. Persons who received preliminary Positive results only- No confirmatory test</td></tr>
<tr><td>T1. Tested Confidentially</td><td>T2. Tested Anonymously</td><td rowspan="2">Persons having sex without a condom</td></tr>
<tr><td>Persons having sex without a condom</td><td>Persons having sex without a condom</td></tr>
<tr><td>IDU- Male IDU</td><td>MSM- Black, ages 20 and up</td><td>MSM- Black, ages 20 and up</td></tr>
<tr><td>IDU- Female IDU</td><td>MSM- White, all ages groups</td><td>MSM- White, all ages groups</td></tr>
<tr><td>MSM- Black, ages 20 and up</td><td>IDU- Male IDU</td><td>IDU- Male IDU</td></tr>
<tr><td>MSM- White, all ages groups</td><td>IDU- Female IDU</td><td>IDU- Female IDU</td></tr>
<tr><td>Heterosexual- Black women, all ages</td><td>Heterosexual- Black women, all ages</td><td>Heterosexual- Black women, all ages</td></tr>
<tr><td>MSM/IDU- all ages and races</td><td>MSM/IDU- all ages and races</td><td>MSM/IDU- all ages and races</td></tr>
<tr><td colspan="3">P3. Untested in the Past 12 Months</td></tr>
<tr><td rowspan="4">P5. High Risk individuals</td><td colspan="2">T4. MSM- Black</td></tr>
<tr><td colspan="2">T5. MSM- Hispanic</td></tr>
<tr><td colspan="2">T6. Heterosexual- Black females</td></tr>
<tr><td colspan="2">T7. Heterosexual- All other females</td></tr>
<tr><td>P6. Moderate/Low Risk</td><td colspan="2">T8. Not tested in past 24 months- All groups</td></tr>
</table>

	including substance abusers, homeless persons, inmates, minorities, mentally ill.
	T9. Not tested in past 48 months- All groups including substance abusers, homeless persons, inmates, minorities, mentally ill.

*Persons not posttest counseled are defined as those who were not given test results on preliminary test. This includes anyone who did not have yes checked for this question.

Notes on development of Matrix:

The matrix on persons tested in the last year (2009) was developed by analyzing Kentucky's Counseling Testing and Referral (CTR) data in conjunction with prioritized populations by the community planning group.

Overall analyses from CTR data indicate that majority of testers by sex were female overall, MSM by risk group, and by race more whites, blacks and Hispanics respectively. Since data from CTR are only a sample of persons testing at the 225 testing sites/locations around the state including: local health departments, disease intervention specialist sites and at Community Based Organizations (CBOs), they do not include information from some testing sites such as private facilities, and thus are not necessarily representative of the general population.

Therefore, the matrix on persons tested in the last 12 months utilized CTR data to prioritize target groups among persons not posttest counseled and testing either confidentially or anonymously. First priority was given to persons who had anal or vaginal sex within the previous 12 months without using a condom. By behavioral risk group among persons testing confidentially, persons who were Injection Drug Users (IDU) or had sex with IDU or shared IDU equipment followed by MSM had the highest number of testers not posttest counseled. Among persons testing anonymously, MSM followed by persons who were Injection Drug Users (IDU) or had sex with IDU or shared IDU equipment had the highest number of testers not posttest counseled. Target groups from these parent behavioral risk groups were then derived from the sub groups prioritized by the planning group for HIV prevention interventions. Target groups for persons who received preliminary test results only and no confirmatory test were derived similarly to persons testing anonymously due to comparable data from CTR.

HIV surveillance data on late testers as of June 30, 2011 were used as a proxy indicator of persons untested in the past 12 months. Demographic groups at highest risk for late testing (when HIV infection has progressed to AIDS within twelve months or less) were prioritized. The highest percentage of late testers over the most recent 10.5 year

period (January 1, 2001 through June 30, 2011) was MSM- 45%. Of all the 430 MSM testing late, 74% were white, 18% were black and 7% Hispanic. Though the highest percentages of late testers were among white MSM, Kentucky's epidemiologic profile indicates a disproportionate impact of HIV disease among blacks and Hispanics in comparison to whites. Therefore, black MSM and Hispanic MSM are prioritized in the MSM category as target groups. Persons reporting heterosexual contact with a person that is HIV positive or is at risk for HIV infection e.g. an injection drug user had the second highest percentage of late testers (17%). Of the 164 heterosexual late testers, 57% are female. Among the female late testers, 59% are black, 28% are white, and 10% are Hispanic. Black females, followed by all other females were prioritized within the heterosexual category.

Lastly, persons untested within the last 24 and 48 months with moderate and/or low risk were selected based on surveillance data which indicate injection drug users (IDU) as the third highest behavioral group testing late. Anecdotal information from care coordinators, the community planning group on special populations that are disproportionately impact by HIV disease were also incorporated, though there may not exist strong data collection system. .

Estimated of number of Kentuckians living with HIV infection who were unaware of their status as of December 31, 2009

This estimate applies the CDC national estimate (national proportion undiagnosed) to Kentucky data using the estimated back calculation (EBC) methodology. The national proportion of undiagnosed HIV infections
is 21%[1].

As of June 30, 2011, there were 4,957 Kentuckians living with HIV infection (regardless of progression to AIDS) at the end of 2009. Therefore, using the
EBC methodology, there were 1,317 persons estimated to be living with HIV infection who were unaware of their status as of December 31, 2009.

Kentucky undiagnosed estimate= 0.21/0.79*4,957 = 1,317 persons

[1]Campsmith, M., Rhodes, P., Hall, H. I., Green, T. A. (2010). Undiagnosed HIV Prevalence Among Adults and Adolescents in the United States at the End of 2006. ***J Acquir Immune Defic Syndr*. 2010;53:619–624.**

Behavioral Profile of Newly Diagnosed HIV Infections among Kentuckians within the Most Recent 5 Year Period (2006-2010)

New MSM Diagnoses (2006-2010), Kentucky

HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adult/Adolescent Men who have Sex with Men (MSM) by Age at HIV Diagnosis and Race/ Ethnicity, Kentucky, as of June 30, 2011**

	White		Black		Hispanic		Total	
Age at Diagnosis	No.	%	No.	%	No.	%	No.	%
13-19	10	2%	47	17%	1	2%	58	7%
20-29	155	28%	114	42%	19	44%	288	33%
30-39	166	30%	52	19%	14	33%	232	27%
40-49	168	31%	37	14%	5	12%	210	24%
50+	50	9%	20	7%	4	9%	74	9%
Total	549	100%	270	100%	43	100%	862	100%

*Regardless of disease progression
**Includes persons with MSM/IDU mode of transmision
Data not inclusive of persons with other/unknown race/ethnicity
Note: Percentages may not total 100% due to rounding

New HIV infections among MSM were highest among whites (549), then blacks (270) and His- panics (43).

By race/ethnicity, the highest percentage of cases among whites was aged 40-49 years at time of diagnosis. Among minorities, the highest percentages were in their 20s at time of diagnosis.

IDU New Diagnoses (2006-2010), Kentucky

HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adult/Adolescent Injection Drug Users (IDU) by Age at HIV Diagnosis and Race/ Ethnicity, Kentucky, as of June 30, 2011

	White		Black		Hispanic		Total	
Age at Diagnosis	No.	%	No.	%	No.	%	No.	%
13-19	1	2%	1	2%	0	0%	2	2%
20-29	11	21%	3	6%	0	0%	14	13%
30-39	18	35%	9	18%	1	50%	28	27%
40-49	18	35%	19	38%	0	0%	37	36%
50+	4	8%	18	36%	1	50%	23	22%
Total	52	100%	50	100%	2	100%	104	100%

*Regardless of disease progression
**Includes persons with MSM/IDU mode of transmision
Data not inclusive of persons with other/unknown race/ethnicity
Note: Percentages may not total 100% due to rounding

HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adult/Adolescent Injection Drug Users (IDU) by Sex and Race/ Ethnicity, Kentucky, as of June 30, 2011

	White		Black		Hispanic		Total	
Sex	No.	%	No.	%	No.	%	No.	%
Male	30	58%	34	68%	2	100%	66	63%
Female	22	42%	16	32%	0	0%	38	37%
Total	52	100%	50	100%	2	100%	104	100%

*Regardless of disease progression
Data not inclusive of persons with other/unknown race/ethnicity
Note: Percentages may not total 100% due to rounding

Heterosexual New Diagnoses (2006-2010), Kentucky

HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adult/Adolescent Persons who had Heterosexual Contact by Age at HIV Diagnosis and Race/ Ethnicity, Kentucky, as of June 30, 2011

	White		Black		Hispanic		Total	
Age at Diagnosis	No.	%	No.	%	No.	%	No.	%
13-19	3	4%	1	1%	2	13%	6	3%
20-29	20	25%	13	16%	5	31%	38	21%
30-39	25	31%	27	33%	8	50%	60	34%
40-49	24	30%	32	40%	1	6%	57	32%
50+	9	11%	8	10%	0	0%	17	10%
Total	81	100%	81	100%	16	100%	178	100%

*Regardless of disease progression

Data not inclusive of persons with other/unknown race/ethnicity

Note: Percentages may not total 100% due to rounding

HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adult/Adolescent Persons who had Heterosexual Contact by Sex and Race/ Ethnicity, Kentucky, as of June 30, 2011

	White		Black		Hispanic		Total	
Sex	No.	%	No.	%	No.	%	No.	%
Male	34	42%	30	37%	7	44%	71	40%
Female	47	58%	51	63%	9	56%	107	60%
Total	81	100%	81	100%	16	100%	178	100%

*Regardless of disease progression

Data not inclusive of persons with other/unknown race/ethnicity

Note: Percentages may not total 100% due to rounding

No Risk Identified (NIR) New Diagnoses (2006-2010), KY

HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adult/Adolescent Persons who had no Identified Risk (NIRs) by Age at HIV Diagnosis and Race/ Ethnicity, Kentucky, as of June 30, 2011

	White		Black		Hispanic		Total	
Age at Diagnosis	No.	%	No.	%	No.	%	No.	%
13-19	12	5%	14	5%	2	4%	28	5%
20-29	47	19%	66	25%	18	32%	131	23%
30-39	60	24%	59	23%	21	38%	140	25%
40-49	84	34%	70	27%	10	18%	164	29%
50+	44	18%	52	20%	5	9%	101	18%
Total	247	100%	261	100%	56	100%	564	100%

*Regardless of disease progression

Data not inclusive of persons with other/unknown race/ethnicity

Note: Percentages may not total 100% due to rounding

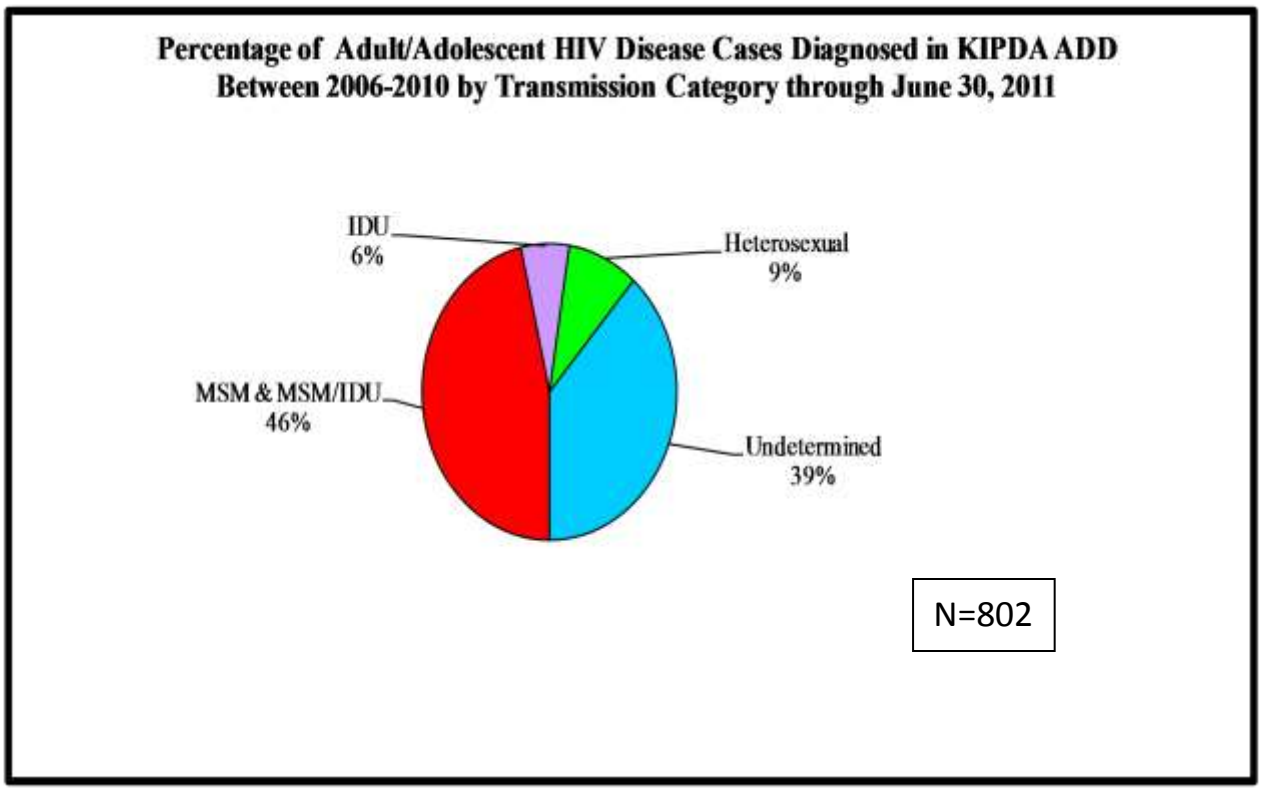
HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adult/Adolescent Persons who had no Identified Risk (NIRs) by Sex and Race/ Ethnicity, Kentucky, as of June 30, 2011

	White		Black		Hispanic		Total	
Sex	No.	%	No.	%	No.	%	No.	%
Male	173	70%	174	67%	42	75%	389	69%
Female	74	30%	87	33%	14	25%	175	31%
Total	247	100%	261	100%	56	100%	564	100%

*Regardless of disease progression

Data not inclusive of persons with other/unknown race/ethnicity

Note: Percentages may not total 100% due to rounding



There were 802 (46%) newly diagnosed HIV adult/adolescent infections residing in KIPDA during the time period 2006-2010. The distribution of these cases by mode of transmission is shown above.

Bluegrass ADD Behavioral Profile– Continued

HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adults/Adolescents Residing in Bluegrass ADD at time of HIV Diagnosis by Mode of Transmission and Race/ Ethnicity, Kentucky, as of June 30, 2011

	MSM &MSM/IDU**		IDU		Heterosexual		No Risk		Total	
Race/Ethnicity	No.	%	No.	%	No.	%	No.	%	No.	%
White	153	66%	10	43%	11	42%	47	49%	221	59%
Black	57	25%	11	48%	11	42%	33	35%	112	30%
Hispanic	21	9%	2	9%	4	15%	15	16%	42	11%
Total	231	100%	23	100%	26	100%	95	100%	375	100%

*Regardless of disease progression
**Includes persons with MSM/IDU mode of transmision
Data not inclusive of persons with other/unknown race/ethnicity
Note: Percentages may not total 100% due to rounding

Among MSM& MSM/IDU, the highest percentages of new diagnoses were white. Blacks had the highest percentages of new diagnoses among IDU and had a comparable percentage to whites with heterosexual mode of transmission.

HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adults/Adolescents Residing in Bluegrass ADD at time of HIV Diagnosis by Age at HIV Diagnosis and Race/ Ethnicity, Kentucky, as of June 30, 2011

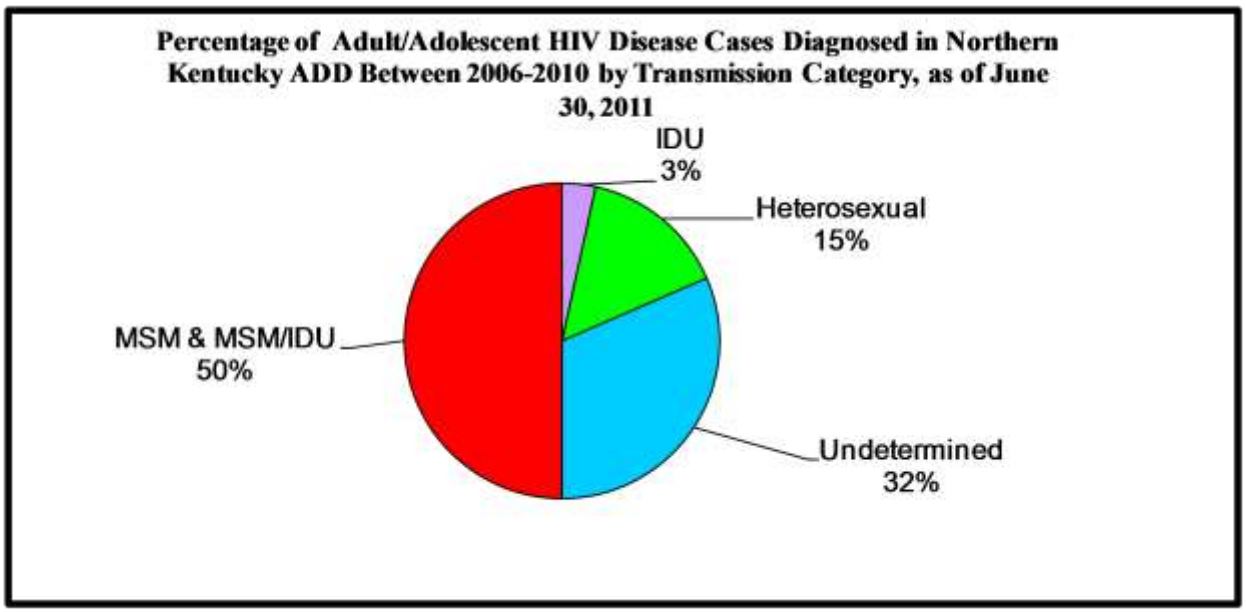
	MSM &MSM/IDU**		IDU		Heterosexual		No Risk		Total	
Age at HIV Dx	No.	%	No.	%	No.	%	No.	%	No.	%
13-19	10	4%	0	0%	0	0%	2	2%	12	3%
20-29	87	37%	1	4%	4	15%	18	19%	110	29%
30-39	63	27%	9	39%	11	41%	29	30%	112	29%
40-49	52	22%	8	35%	10	37%	35	36%	105	28%
50+	22	9%	5	22%	2	7%	13	13%	42	11%
Total	234	100%	23	100%	27	100%	97	100%	381	100%

*Regardless of disease progression
**Includes persons with MSM/IDU mode of transmision
Data not inclusive of persons with other/unknown race/ethnicity
Note: Percentages may not total 100% due to rounding

Among MSM& MSM/IDU, the highest percentages of new diagnoses were aged 20-29 years at diagnosis. Among IDU and heterosexuals, the highest percentages of new

diagnoses were in their 30s at time of diagnosis. The highest percentage of cases without risk were aged 40-49 years at time of diagnosis.

Northern Kentucky ADD Behavioral Profile



There were 146 (8%) newly diagnosed HIV adult/adolescent infections residing in Bluegrass ADD during the time period 2006-2010. The distribution of these cases by mode of transmission is shown above.

Northern Kentucky ADD Behavioral Profile– Continued

HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adults/Adolescents Residing in Northern Kentucky ADD at time of HIV Diagnosis by Mode of Transmission and Race/ Ethnicity, Kentucky, as of June 30, 2011

	MSM &MSM/IDU**		IDU		Heterosuxual		No Risk		Total	
Race/Ethnicity	No.	%	No.	%	No.	%	No.	%	No.	%
White	62	85%	2	40%	12	55%	27	59%	103	71%
Black	9	12%	3	60%	8	36%	14	30%	34	23%
Hispanic	2	3%	0	0%	2	9%	5	11%	9	6%
Total	73	100%	5	100%	22	100%	46	100%	146	100%

*Regardless of disease progression
**Includes persons with MSM/IDU mode of transmision
Data not inclusive of persons with other/unknown race/ethnicity
Note: Percentages may not total 100% due to rounding

Among MSM& MSM/IDU, Heterosexuals and persons without risk, the highest percentages of new diagnoses were white. There is a small number of IDU cases, therefore data should be interpreted with caution.

HIV Infections* diagnosed in the most recent 5 year period (2006-2010) among Adults/Adolescents Residing in Northern Kentucky ADD at time of HIV Diagnosis by Age at HIV Diagnosis and Race/ Ethnicity, Kentucky, as of June 30, 2011

	MSM &MSM/IDU**		IDU		Heterosuxual		No Risk		Total	
Age at HIV Dx	No.	%	No.	%	No.	%	No.	%	No.	%
13-19	2	3%	0	0%	1	5%	3	7%	6	4%
20-29	19	26%	1	20%	8	36%	7	15%	35	24%
30-39	20	27%	1	20%	3	14%	16	35%	40	27%
40-49	22	30%	2	40%	7	32%	12	26%	43	29%
50+	10	14%	1	20%	3	14%	8	17%	22	15%
Total	73	100%	5	100%	22	100%	46	100%	146	100%

*Regardless of disease progression
**Includes persons with MSM/IDU mode of transmision
Data not inclusive of persons with other/unknown race/ethnicity
Note: Percentages may not total 100% due to rounding

Concurrent Diagnoses (2006-2010), Kentucky

Kentucky HIV Infections Diagnosed in the Most Recent 5 Year Period (2006-2010) that were Diagnosed Concurrently with AIDS (within 30 Days of HIV Diagnosis) by Sex, Age at Diagnosis, Race/Ethnicity, and Transmission Category, as of June 30, 2011

	HIV *with* Concurrent AIDS Diagnosis***		HIV *Without* Concurrent AIDS Diagnosis**		Total HIV Disease Diagnoses*	
Characteristics	**N**	**% (1)**	**N**	**% (1)**	**N**	**% (1)**
SEX						
Male	375	82%	248	19%	623	36%
Female	82	18%	1034	81%	1116	64%
AGE AT DIAGNOSIS						
13-19	6	1%	92	7%	98	6%
20-29	72	16%	407	32%	479	28%
30-39	138	30%	331	26%	469	27%
40-49	158	35%	317	25%	475	27%
50+	83	18%	135	11%	218	13%
RACE/ETHNICITY- Female						
White, Not Hispanic	24	29%	119	48%	143	43%
Black, Not Hispanic	47	57%	107	43%	154	47%
Hispanic	8	10%	15	6%	23	7%
Other/Unknown	3	4%	7	3%	10	3%
RACE/ETHNICITY- Male						
White, Not Hispanic	229	61%	557	54%	786	56%
Black, Not Hispanic	95	25%	413	40%	508	36%
Hispanic	46	12%	48	75%	94	7%
Other/Unknown	5	1%	16	2%	21	1%
TRANSMISSON CATEGORY						
MSM(2)	201	44%	673	52%	874	50%
IDU(3)	41	9%	63	5%	104	6%
Heterosexual(4)	54	12%	130	10%	184	11%
Undetermined(5)	161	35%	416	32%	577	33%
TOTAL	**457**	**100%**	**1282**	100%	**1739**	**100%**

*2006 through 2010

**Without AIDS diagnosis 30 days after initial HIV diagnosis. Includes both HIV (non AIDS) cases and those with an AIDS diagnosis more than 30 days after initial HIV diagnosis.

***Concurrent is defined as having an HIV and AIDS diagnosis within 30 days.

(1) Percentages may not total to 100 due to rounding. Percentages for each characteristic add up to 100% by column. (2) MSM = Men Having Sex With Men. Includes persons with MSM/IDU mode of transmission (3) IDU = Injection Drug Use.

(4) "Heterosexual" includes persons who have had heterosexual contact with a person with HIV or at risk for HIV.

(5) "Undetermined" refers to persons whose mode of exposure to HIV is unknown. This includes persons who are under investigation, dead, lost to investigation, refused interview, and persons whose mode of exposure remain

undetermined after investigation.

Concurrent Diagnoses (2006-2010), KIPDA ADD

Table C.2. HIV Infections Diagnosed in the Most Recent 5 Year Period (2006-2010) among Adults/Adolescents Residing in KIPDA that were Diagnosed Concurrently* with AIDS (within 30 Days of HIV Diagnosis) by Sex, Age at Diagnosis, Race/Ethnicity, and Transmission Category, as of June 30, 2011

	MSM**		IDU		HETERO-SEXUAL		NO RISK		TOTAL	
Characteristics	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
SEX										
Male	66	100%	16	73%	8	38%	50	69%	140	77%
Female	N/A	N/A	6	27%	13	62%	22	31%	41	23%
AGE AT DIAGNOSIS										
13-19	2	3%	0	0%	0	0%	1	1%	3	2%
20-29	9	14%	2	9%	0	0%	10	14%	21	12%
30-39	25	38%	5	23%	10	48%	17	24%	57	31%
40-49	19	29%	12	55%	9	43%	25	35%	65	36%
50+	11	17%	3	14%	2	10%	19	26%	35	19%
RACE/ETHNICITY										
White, Not Hispanic	42	64%	9	41%	3	14%	23	32%	77	43%
Black, Not Hispanic	19	29%	13	59%	17	81%	35	49%	84	46%
Hispanic	3	5%	0	0%	0	0%	10	14%	13	7%
Other/Unknown	2	3%	0	0%	1	5%	4	6%	7	4%
TOTAL	**66**	**100%**	**22**	**100%**	**21**	**100%**	**72**	**100%**	**181**	**100%**

*Concurrent is defined as having an HIV and AIDS diagnosis within 30 days.
**Includes persons with MSM/IDU mode of transmision
Note: Percentages may not total to 100 due to rounding. Percentages for each characteristic add up to 100% by column.

Concurrently Diagnosed Narrative:

Between 2006 and 2010, there were 1,739 HIV infections diagnosed in Kentucky, and of these, 457 (26%) were concurrently diagnosed with AIDS. Table C.1 presents the number of concurrently diagnosed individuals by sex, age at diagnosis, race/ethnicity, and transmission category. As of June 30, 2011, males (82%), individuals between the ages of 40 and 49 (35%), and those with an MSM risk (44%) were more likely to have a concurrent diagnosis. Among females, non-Hispanic Blacks (57%) were more likely to be concurrently diagnosed, whereas non-Hispanic Whites were more likely to have a concurrent diagnosis among males, compared to the other racial/ethnic groups.

The number of concurrently diagnosed individuals during this time period was

stratified by the top three area development districts (ADD): KIPDA, Bluegrass, and Northern KY. The three ADDs made up 75% (342) of the individuals concurrently diagnosed in KY. Table C.2 presents the percentages of concurrently diagnosed individuals for the KIPDA region by sex, age, and race/ethnicity for each transmission category. Overall, males (77%), individuals between the ages of 40 and 49 (36%), and blacks (46%) were more likely to have had a concurrent AIDS diagnosis compared to their counterparts. Among MSM, a large percentage of individuals concurrently diagnosed were in their 30s (38%), followed by those in their 40s (29%). For IDUs, males (73%) were more likely to be concurrently diagnosed compared to female IDUs, and they were more likely to be older, with 55% of IDUs falling in the 40 to 49 age range. Concurrently diagnosed heterosexuals were more likely to be females (62%) and aged 30 to 49 years at time of diagnosis. Those who did not have a risk reported, were more likely male (69%). Among the IDUs, Heterosexual contact, and NRR groups, non- Hispanic blacks were more likely to be concurrently diagnosed (Figure C.1). For MSM, non-Hispanic whites were more likely to be concurrently diagnosed.

Social Determinants of Health and Structural Factors

The term *social determinants of health* (SDH) refers to the complex, integrated, and overlapping social structures and economic systems that include social and physical environments and health services. These determinants are shaped by the level of income, power, and resources at global, national, and local levels. They are also often influenced not only through personal choices, but through policy choices as well.

CDC proposes in its White Paper, "*Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States,"* that there are five determinants of population health generally recognized in the scientific literature: (1) biology and genetics (e.g., sex), (2) individual behavior (e.g., alcohol or injection drug-use, unprotected sex, smoking), (3) social environment (e.g., discrimination, income, education level, marital status), (4) physical environment (e.g., place of residence, crowding conditions, built environment [i.e., buildings, spaces, transportation systems, and products that are created or modified by people]), and (5) health services (e.g., access to and quality of care, insurance status).

A review of the Kentucky HIV rates presents an alarming picture of HIV as a disease impacting people of color at alarmingly high rates. Although African Americans make

up only 8% of the KY population, they represent 31% of cumulative AIDS cases in the state. Clearly, this impact must reflect on ability to access health promotion and health care services, and raises concerns about the need to further understand and address health disparities among this population.

For many vulnerable individuals, *homophobia* presents a potent barrier to effective HIV prevention and to compassionate care. In qualitative interviews with multiple stakeholders, the issue of HIV stigma was cited as a major barrier to individuals accessing services and as a challenge to retention in care.

Given this reality, the HIV/AIDS Branch, since its inception, has funded community organizations and agencies with the history and ability to provide services to diverse client populations. In Louisville and Lexington, agencies serving African American clients have had a significant impact on the number of prevention clients being served and the success of HIV testing programs. These community-based partners have proven to be invaluable in the delivery of high quality prevention services and case management services to minority consumers.

Though the number of Latino persons living with HIV in Kentucky remains relative small, the rates of AIDS for Hispanic/Latino Kentuckians is ten times higher than HIV rates among Caucasian Kentuckians. This trend underscores the need for innovative approaches to prevention and HIV testing among this population.

Of particular interest with regards to community engagement, are the communities of refugees and immigrants that are becoming more and more prevalent within Kentucky. Among these particular populations, there are additional barriers to providing HIV prevention and care services. For example, more than 80 different *languages/dialects* have been reported among these often small, close-knit, and isolated communities. Effective HIV prevention efforts require multiple strategies, often beginning with educational materials. Just to create language-specific prevention materials for 80-plus languages is cost-prohibitive for many already-financially-stretched programs.

Additionally, *cultural differences* pose problems for prevention and care services. For example, the concept of *confidentiality* is crucial to providing HIV-related services. However, for some of Kentucky's refugee/immigrant populations, there is no such concept of confidentiality in their culture as all their communication is at a "tribal level" – simply put, if <u>one</u> knows, <u>all</u> know.

Compounding these barriers for these populations with regards to HIV prevention and care services are often issues of legal status, denial of HIV, lack of trust, and competing

life priorities. To address the needs of the refugee and immigrant populations of Kentucky, education and training must take place not only among the community members but also among the prevention and care providers who serve them in order to affect positive and sustaining change.

Driven by the Needs Assessment Committee and input from community partners and stakeholders, the Kentucky Part B program has developed and implemented a priority for the allocation of funding to serve those most in need. The greatest priority is Kentucky AIDS Drug Assistance Program which provides prescribed formulary approved medications to all eligible persons in Kentucky living with HIV and AIDS. Program funds may also be used to purchase health insurance for eligible clients and for services that enhance access to, adherence to, and monitoring of drug treatments. The second largest priority is Direct Services. This program maintains client enrollment in direct medical and supportive services (Kentucky HIV Care Coordinator; KHCCP). The Kentucky Health Insurance Assistance Program promotes cost containment and savings to AIDS Drug Assistance Program by assisting eligible clients with insurance premiums. The Emerging Communities program provides enhanced support for targeted minority populations for education, outreach, early intervention and testing in order to provide seamless linkage to medical treatment for newly diagnosed minorities. Emerging Communities are defined as those reporting between 500 and 999 cumulative reported AIDS cases over the most recent 5 years. The Minority Aids Initiative/Early Identification Individuals HIV/AIDS program provides capacity building funding to Community Leaders for activities in communities of targeted minority populations for outreach and education to link to care services and subsequent enrollment into KADAP.

Beginning in 2011, the health department has executed agreements with non-traditional partners in an attempt to reach hard-to-reach populations that are in need of prevention services and HIV testing. This initiative has resulted in increased participation among a number of agencies and also engaged constituents for prevention who had not been reached through already existing partnerships.

Historically, many public health efforts have focused on individual behaviors. SDH typically refers to the latter three categories mentioned above (i.e., social environment, physical environment, and health services), which *are not* controllable by the individual, but affect the individual's environment. The HIV/AIDS Branch is committed to structural and policy changes to address some of the issues that confront populations disproportionately impacted by HIV and competing barriers to effectively accessing prevention and care services. Some of these changes include condom distribution and concomitant social marketing efforts aimed at increasing the acceptability of condoms in marginalized populations.

For example, a number of structural factors impact the ability of the Part B grantees to diagnose individuals living with HIV and to link them to care. First among these are statutes allowing for anonymous HIV antibody testing. The ability of an individual to test anonymously means it can be difficult to initiate partner counseling services and it may be difficult to find the patient and link them to care.

In addition, the absence of policy within the Department of Corrections supporting testing of inmates makes tracking and responding to HIV in correctional settings very difficult. While individuals may voluntarily request HIV testing, the absence of routine practice has meant that the patients living with HIV who are unaware of their status may very well be housed for a long time without receiving treatment. Further, since condoms are not provided in KY correctional settings, the possibility of HIV transmission while inmates are incarcerated remains quite possible.

Finally, the lack of a legislative mandate regarding prenatal testing makes HIV screening in the first trimester a voluntary measure. While privacy and informed consent are critical, there are some significant public health benefits to mothers—and their unborn children—when HIV screening is incorporated into routine prenatal care.

Importantly, income inequities also serve as proxy measures for other socio-economic inequities. The CDC emphasizes the impact of social exclusion on health and well-being, with social exclusion being a shorthand term for what can happen when people suffer from a combination of linked problems, such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown. The state community planning group—Kentucky HIV/AIDS Planning and Advisory Council [KHPAC]—has been engaged since 1996 to encourage sensitivity to the needs of vulnerable populations. To the extent that this sensitivity brings about effective strategies to address possible barriers to inclusion and strives to consistently link planned activities to the needs of the most vulnerable populations seems logically to be one strategy for substantive community engagement.

In addition to other factors, a final important factor must be addressed in responding to the disparities faced by individuals with HIV in Kentucky: the obstacles for rural health care provision. Clearly, *access to high-quality medical care* [and subsequent health promotion messages] is a challenge in rural America because of distances to large hospitals and health facilities. Moreover, this distance combined with *generally poorer economic conditions* creates a huge concern in accessing care. Even further compounding these issues is *stigma of HIV in rural Kentucky* which has been consistently reported in needs assessment activities as a major barrier for effective prevention of HIV and of compassionate response.

To address this challenge, the health department relies heavily on the regional partnerships with medical and prevention providers throughout the state. Partnering with these entities allows agencies developing service plans to build on the relative strengths and challenges in their communities to guide prevention and care activities in ways that address stigma and increase access. The role of community prevention partners in providing HIV testing services has been crucial in attempting to address these significant gaps. In addition, supporting county health departments throughout the state make the availability of HIV testing accessible to all Kentuckians.

The HIV/AIDS Branch is committed to the goal of reducing disparities and addressing social determinants of health in the next several years. The comprehensive plan activities combining community partnerships, reliance on strong local health department services, structural interventions, and policy changes are thought to ameliorate some of the most difficult challenges faced by vulnerable, disenfranchised populations.

Source: Centers for Disease Control and Prevention. Establishing a Holistic Framework to Reduce Inequities in HIV, Viral Hepatitis, STDs, and Tuberculosis in the United States. Atlanta (GA): U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; October 2010.

Description of Existing Resources

The Kentucky Department for Public Health receives approximately $2.6 million in HIV prevention funding to support HIV prevention and HIV rapid testing from the Centers for Disease Control and Prevention (CDC). In turn, the HIV/AIDS Branch provides support and funding for high impact prevention activities as well as conventional and rapid HIV testing programs to eight prevention sites across three regions. In the East Region, the prevention sites include: Lexington-Fayette County Health Department, Northern Kentucky Independent District Health Department, and AIDS Volunteers, Inc. (AVOL). In the West Region, the preventions sites are: Barren River District Health Department, Matthew 25 AIDS Services, and Purchase District Health Department. In the North Central Region, the prevention sites are: Volunteers of America – Louisville and the Louisville Metro Health Department. Additionally, the KY HIV prevention program continues to partner with all four of the state's Ryan White Part C clinics to provide prevention and testing services.

In addition to these existing partners, beginning in 2011 the HIV/AIDS Branch has funded eight agencies which are referred to as 'non-traditional' partners. In an effort to identify individuals unaware of their status and reach out to communities disproportionately impacted by HIV, these efforts represent a commitment to HIV testing and prevention interventions for individuals who may be missed in existing prevention efforts. A number of these agents work with refugee populations, African-American and Latino populations, substance users, and individuals who do not identify as having risk for HIV.

The Kentucky Department for Public Health HIV/AIDS Branch, in collaboration with the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC) and numerous other HIV prevention providers (including Matthew 25 AIDS Services, Inc.) works to ensure prevention and care services meet the needs of the people of the Commonwealth of Kentucky. Prevention efforts are included below in the description of the six Ryan White Part B direct service regions.

The Ryan White Part B Program, administered by the HIV/AIDS Branch is funded by the Health Resources and Services Administration (HRSA) to provide care and HIV medication to Kentuckians who are without health insurance and are below 300% of the Federal Poverty Limit.

It is important to note that because the HIV program houses ***Care*** and ***Prevention*** in the same Branch, the opportunities for collaboration and coordination of efforts are pronounced. Frequently, staff in Prevention offer insight and guidance on reaching people living with HIV and thus, help them to learn their status. Similarly, the Care staff work closely with the Prevention team to enhance positive prevention in care settings and to creatively enhance linkage to care services.

Kentucky has six (6) Part B direct services regions designed to provide local access to HIV/AIDS care and services statewide. Every individual who receives direct services in Kentucky is assigned a Care Coordinator. This is the mechanism by which clients receive mandatory medical case management and an Individual Care Plan (ICP) is developed for each client and is tailored to their respective needs. This process involves a review of the client's specific medical and supportive needs, including a mental health and substance abuse assessment. Other factors such as income level, housing status, social and family support systems, individual risk factors, etc., are also evaluated for the ICP. The Care Coordinator and the client work collaboratively to achieve the goals of the ICP, and referrals are made through a network of pertinent service providers in each region.

Case managers are the main link to treatment for many infected individuals, the Care Coordinators engage in case management with clients who have been out of touch with the Part B program and quickly refer individual to clinical treatment before the client exits the facility and possibly becomes lost to care again. Also, through the partnerships with Part C clinics, clients often do not have to travel further for medical treatment. This is particularly valuable in the rural regions where transportation is cited as a key need for HIV/AIDS clients. The Part B program plans to enhance opportunities for medical transportation through increased car and van-pooling of clients.

The six Part B regions are described below:

1. Bluegrass Care Clinic (BCC) – Central and Eastern Region, Lexington, KY

- This agency operates as a "one stop shop," providing Ryan White Part B services, Part C, mental health and HIV prevention services. This model allows clients to receive case management, prevention services and medical care on the same day at one facility, minimizing travel and other expenses. BCC is a clinic on the campus of the University of Kentucky Hospital. This proximity expedites client access to high quality care of various disciplines.

- BCC also coordinates with Lexington Fayette County Health Department to provide HOPWA services. Other linkages include Movable Feast, Comprehensive Care, and other private infectious disease physicians and oral health providers.
- To ensure the provision of medical services to underserved regions of north eastern Kentucky, BCC has partnered with the Tri-State Infectious Disease Clinic for client care.
- BCC also refers to the Portsmouth, Ohio Health Department, which provides treatment for infectious disease patients.

2. Cumberland Valley District Health Department (CVDHD) – Eastern Region, Manchester, KY

- The CVDHD receives Part B funding for direct services to clients in the eastern region of the state.
- CVDHD region has a deficiency of both primary and specialty medical care. Due to this disparity, over 100 clients in this area are transported, 2 to 3.5 hours, to BCC for case management and onsite medical care.
- CVDHD receives HOPWA funding for the eastern part of Kentucky. HOPWA funding subsidizes the costs associated with securing safe and affordable housing for clients.
- Prevention services are available through collaboration with the Lexington Fayette County Health Department and the Volunteer of America, Lexington, KY.

3. Heartland Cares, Inc. – Western Region, Paducah, KY

- Heartland Cares operates as a "one stop shop," providing Ryan White Part B services, Part C (medical treatment), mental health and HIV prevention services. This model allows for clients to receive case management, prevention services and medical care on the same day at one facility, minimizing travel and other expenses.
- Due to the remote location of this agency, Heartland Cares has developed a referral network of oral health providers.
- Heartland Cares receives HOPWA funding for the western part of Kentucky.
- Heartland Cares receives separate funding from the state to provide HIV prevention initiatives and linkages are in place to provide a broad spectrum of HIV prevention services, including HIV testing and risk reduction.
- Linkages have been established with the regional Comprehensive Care System which is comprised of facilities able to treat physical and mental health conditions including substance abuse.

4. Matthew 25 AIDS Services, Inc. – Western and South Central, Henderson, KY

- Matthew 25 operates as a "one stop shop," providing Ryan White Part B services, Part C (medical treatment), mental health and HIV preventions services located at the main office in Henderson. This model allows for clients to receive case management, preventions services and medical care on the same day at one facility, minimizing travel and other expenses.
- Matthew 25 also has offices located in Bowling Green and Elizabethtown providing direct services to clients in each of these locations. Both of these offices have established referral network with private infectious disease physicians. Referrals are made to the regional Comprehensive Care System.
- Oral health services are provided to Matthew 25 clients through a MOU with the Part F clinic at the University of Louisville and their satellite office located in Elizabethtown.
- To enhance client access in this large service area, this agency has partnered with the Davies County Health Department in Owensboro. In this partnership, Matthew 25 has been allotted meeting space at the health department allowing for weekly meetings between Matthew 25 Care Coordinators and area clients. At the health department, clients can receive case management and medical care on the same day at one facility.
- This agency utilizes the University of Louisville's Elizabethtown Part F program (oral health services) as a referral source. In addition, there is a Care Coordinator at the Elizabethtown office which is available to clients at this location.
- Matthew 25 receives direct funding from the CDC to provide HIV prevention testing, risk reduction, prevention initiatives and linkages to care.

5. Northern Kentucky Independent District Health Department (NKIDHD) – Northern Region, Ft. Mitchell, KY

- The NKIDHD receives Part B funding for direct services in the northern region of the state.
- The NKIDHD is located in the far northern part of Kentucky bordering Cincinnati, Ohio. As a result, many client medical referrals are made to the University of Cincinnati Part C medical clinic. Clients are also referred to private infectious disease physicians within the northern Kentucky area.
- This agency also receives a small amount of federal funding for HOPWA.
- A MOU currently exists between this health department and the Droege House. The Droege House is a residential facility in Dayton, Ohio, specializing in substance abuse issues. This facility accommodates HIV positive individuals only.

- Referrals are made to the regional Comprehensive Care System.
- Collaborations with a Disease Investigative Specialist (DIS) and Prevention Specialists provide HIV testing, partnership notification, risk reduction counseling and prevention initiatives for clients.

6. Volunteers of America (VOA) – Louisville Region, Louisville, KY

- VOA receives Part B funding for direct services in the Louisville area of the state.
- The Louisville area contains the largest number of HIV infected individual in the state. Therefore, VOA provides services to the largest number of clients within the state.
- VOA has a standing MOU with the University of Louisville "WINGS" (Part C) medical clinic and routinely refers clients to that location for treatment. Also, VOA has a Care Coordinator housed at the Part C clinic. At this location, clients can receive case management from VOA and medical care on the same day at one facility, minimizing travel and other program expenses.
- VOA is part of the AIDS Services Organization (ASO) in Louisville.
- Collaboration with Seven Counties, VOA Substance Abuse, Louisville/Metro Heath Department and House of Ruth has been established to provide care and services. This collaboration allows service gaps to be filled for residential and non-residential substance abuse and mental health treatment.
- This agency refers clients to the University Of Louisville School Of Dentistry (Part F) for oral health needs.
- VOA is the sole recipient of Emerging Communities (EC) funding through the Ryan White Part B program in the state. EC funds provide medication assistance, labs/x-rays, housing, food and other supportive services to a variety of local agencies in the service region. EC finds also serve eligible clients in the four Louisville/Jefferson county area counties that border the state of Indiana by establishing a MOA with the Hoosier Clinic in Jeffersonville, Indiana. This MOA provides funding to the clinic in order to subsidize medical treatment for referred clients.
- Bi-lateral referrals for prevention and STD specialty care are conducted between VOA and the Louisville/Metro Health Department, which are all on the same floor of the same facility for easier client access.

The Part B Office collaborates closely with the Ryan White partners in the state, many of whom are jointly funded. There are close relationships with all four Part C Clinics [Heartland Cares, Matthew 25, Bluegrass Care Clinic, and WINGS Clinic] and all are both Part B and C recipients. In addition, the WINGS Clinic is also are Part D site.

The State maintains excellent relationships with both Part F dental reimbursement programs located in Louisville and Lexington. Representatives from these Part F grantees participate formally and informally in program planning, grant reviewing, and

providing technical assistance to Part B grantees. In addition, there is a close and ongoing relationship with the Southeast AIDS Training and Education Center based at the University of Kentucky, the Part F AETC grantee for Kentucky. The AETC features prominently in plans for training Part B providers and routinely collaborates with the Part B office on both tailored training for Part B grantees and an annual statewide conference.

Additional care resources are provided through Medicaid reimbursement. Some 903 Kentuckians received care through Medicaid in 2010. The Part B office works closely with the Medicaid office to ensure seamless referral for patients who are Medicaid eligible. The total Medicaid reimbursement in 2009 was $11.7 million dollars. The Veterans Administration Medical Centers provide HIV testing, care, and other critical services to Kentuckians living with HIV. Coordinated out of the Vet Centers in Louisville and Lexington, veterans living with HIV are provided services via a network of more than twenty outpatient care facilities across the State.

In addition to the existing resources listed above, it is important to note that the HIV/AIDS Branch and its community partners are proud of their continued ability to effectively respond to necessary changes in health delivery systems. Perhaps because Kentucky is comparatively small and rural, there is a long-standing history of community members volunteering to help the Branch and an easy collaboration with the community, even on challenging matters. Throughout the 22-year span of Ryan White allocations, the ease in collaboration and ability to adapt to changes in State and Federal policies and funding are exemplary. In addition to these partnerships, other key measures being undertaken by the Branch as outlined in this document will involve attempts to enhance services to individuals not born in the U.S., and boosting HIV care by addressing stigma of HIV throughout the State.

Further, the HIV program is already working closely with partners across the State to prepare for changes associated with the Affordable Care Act [ACA]. This important legislative mandate will allow the number of Kentuckians receiving medical care through Medicaid to grow significantly. It is anticipated that, as Medicaid grows, the need for Ryan White programs to adapt and remain flexible is crucial for patient access. To that end, the state ADAP program has begun a program of insurance reimbursement and looks to expand that initiative in the next few years.
Finally, the Part B office has cultivated and continues to grow relationships with Community Health Centers [CHCs] across the State. Through partnership with the KY Primary Care Association, the Branch looks forward to an expansion of HIV services in reaching more of those in need.

CDC HIV Prevention, PS12-1201 Resource Allocation

One of the goals of the PS12-1201 Resource Allocation is to reduce HIV transmission by building capacity of health departments to focus HIV prevention efforts in communities and local areas, where HIV is most heavily concentrated, to achieve the greatest impact in decreasing the risks of acquiring HIV. Grantees should monitor the HIV/AIDS epidemic within the jurisdiction for program planning, resource allocation and monitoring and evaluation purposes. Grantees should utilize the most current epidemiological and surveillance data and other available data sources to assist in program planning and evaluation.

To ensure that resources are reaching the areas of greatest need, grantees will be required to report annually to CDC on the amount of funding allocated to the areas with 30% or greater of the HIV epidemic and how the funds were used.

Please identify each city/MSA with at least 30% of the HIV epidemic within the jurisdiction. For directly-funded cities, please report areas or zip codes within the MSA with at least 30% of the HIV epidemic within the jurisdiction. If no area represents at least 30% of the HIV epidemic, then identify the top three MSA/MDs, cities, or areas within the jurisdiction that have the greatest burden of disease.			
MSA/CITY	**Percentage of HIV Epidemic**	**Percentage of PS12-1201 Funds Allocated**	**Components and Activities Funded**
Louisville Metro/Jefferson County	46% of newly diagnosed HIV adult/adolescent infections (2006-2010)	**50%**	Targeted HIV Testing and condom distribution in Community settings, routine testing in clinical settings, comprehensive prevention with positives, partner services and Disease Intervention services, community mobilization and social media initiatives,

Gaps in Services/Needs Assessment

OVERVIEW OF THE PROCESS

This document summarizes the efforts of the Kentucky Department for Public Health to analyze unmet needs in HIV prevention and care. In the spirit of the National HIV/AIDS Strategy, a decision was made to conduct an assessment which addressed both the prevention and care gaps in services which would lead to a plan that addressed both prevention and care goals in one document. This document is referred to as the Kentucky HIV/AIDS Strategy and builds on the strengths in the National HIV/AIDS Strategy.

This process was initiated by convening a needs assessment work group to oversee the process. This work group was composed of stakeholders representing a broad range of Kentuckians including HIV prevention providers, HIV care providers, and representatives from all Ryan White programs. In addition to HIV-serving organizations, representatives from Education, Corrections, Mental Health, and Substance Abuse Services in the Kentucky government and a broad range of consumers formed the Needs Assessment Work Group.

An initial plan for the KY Prevention and Care Needs Assessment was proposed by the health department and was presented to the Work Group for comment. Once agreement on a plan was reached, the process for discovering gaps in services and unmet needs has been conducted in several distinct phases.

Initially, a review of past HIV prevention and care documents [e.g. prior comprehensive plans] was conducted. Following this review, a series of key informant interviews was conducted to gather preliminary information about current challenges. This data – gathered from consumers and providers – was used to guide the next phases of the process.

The initial inquiry of stakeholders led to the creation of a statewide web-based survey which was distributed across Kentucky to consumers and providers, as well as, to interested community members. A total of 491 survey responses were obtained – more than 22% of responses came from individuals living with HIV disease from every region of the state.

These findings led to the final process of the needs assessment – a statewide meeting in May 2012 of the Needs Assessment Work Group. The focus of this meeting was to prioritize identified needs and make suggestions to meet these unmet needs. This critical input, as well as careful analysis of surveillance and behavioral data, has led to the creation of strategic goals and objectives.

INITIAL ASSESSMENT

Interviews were conducted with a wide variety of stakeholders from across Kentucky in an attempt to identify important issues. Key informant interviews and focus groups were conducted with prevention and care providers and consumers in March/April 2012. The purpose of this activity was to identify issues affecting service delivery and to frame the next steps in the needs assessment process. All Ryan White Parts in Kentucky had representation on the Needs Assessment Working Group and were intimately involved in the needs assessment process.

In terms of assessment findings, ongoing themes in discussion of barriers to HIV prevention included *stigma and fear of discrimination, lack of access to health care (especially in rural areas), lack of information about HIV, and poor sense of perceived risk*. Difficulties in care access included *economics, geographic concerns, and difficulty accessing key services beyond HIV-specific care*. The *challenges with substance-using and mentally-ill consumers* were identified as concerns.

Regional differences in access and barriers were identified in the early needs assessment process. Given this, the next phases of the activity included an opportunity to break out information by region and particularly to identify gaps in services by region. This level of specificity was thought to make the utility of the needs assessment more relevant and the region-specific input was deemed to be very valuable as the HIV/AIDS Branch began to develop goals and objectives to address barriers.

"People don't talk about HIV in small towns. They think it's a 'Gay' disease and that it happens to people outside of here. No one thinks HIV is a problem here."

The findings from the initial assessment activity led to the development of the web-based survey. A draft of this survey was developed and then distributed after feedback was obtained from the Needs Assessment Work Group. The process of administering the survey and results from the survey follow.

STATEWIDE SURVEY AND FINDINGS

In the 2009 Kentucky Comprehensive Plan identified several concerns, gaps, and unmet needs. The plan does meet the needs of Kentucky PLWHA. In addition to the findings previously mentioned, the following issues should be addressed:

- Stigmatization leads to a major barrier to accessing services & creates a challenge to retention in care, as well as HIV testing for individuals unaware of their status.
- Need to improve access to condoms & education regarding treatment adherence
- Housing and transportation remains a barrier to treatment & problematic
- Provider capacity and capability – need for more training, Medicaid providers, & dentist
- Provider and program staff education on culture & social issues
- Links to the incarcerated & newly released inmates
- Data management systems
- Quality management & evaluation

As one component of data collection for the KY Prevention & Care Needs Assessment, a web-based needs assessment questionnaire was deployed in late April through early May 2012. The snowball technique was used to enlist as many stakeholders as possible throughout the state as survey respondents.

To initiate this technique, the website link to this questionnaire was distributed electronically to members of the Needs Assessment Work Group who were asked to complete the survey themselves and then distribute it among other stakeholders including, but not limited to, persons living with HIV/AIDS, administrators, prevention providers, KHPAC members, state/federal government employees, substance abuse/mental health providers, primary care providers, HIV case managers, HIV clinicians and local health department employees. Additionally, an email invitation with survey website link was sent to individuals from numerous resource lists provided by members of the Needs Assessment Work Group. Further, a paper version of the questionnaire was sent to case managers and their

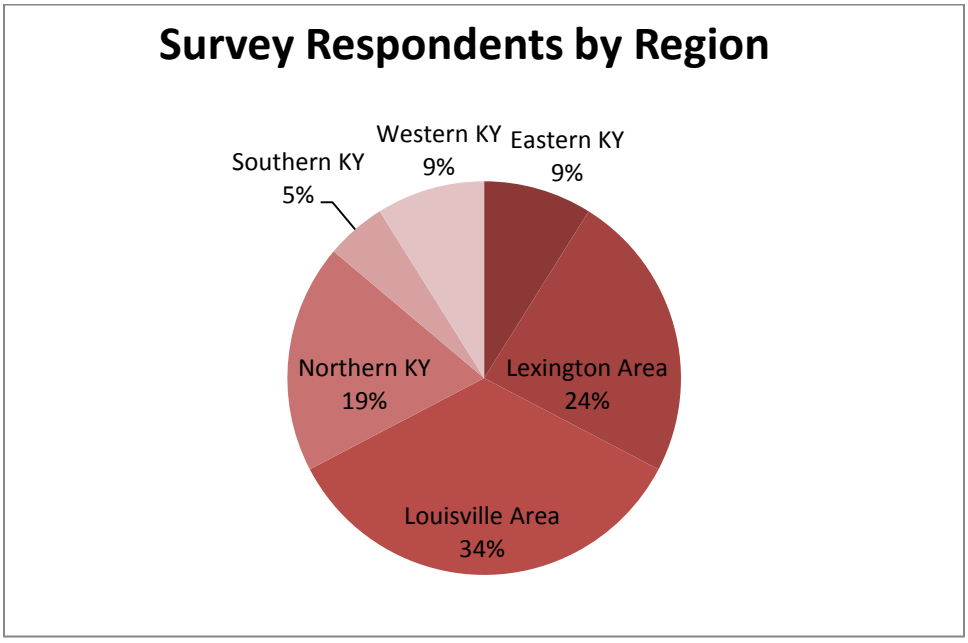
A total of 491 individuals responded to the KY needs assessment questionnaire. Of respondents who self-identified, 22% identified themselves as persons living with HIV/AIDS.

supervisors to capture the input of those individuals who may not have access to the internet. A second reminder email was sent as the deadline for survey completion approached.

The web-based survey received 491 total responses with 73% of those completing every question of the survey. As a result, the total number of respondents for each question/set of questions varies and is noted. Additionally, all percentages are rounded up and therefore may not always add to 100%. Also, a few additional surveys were received by mail after data analysis was completed and therefore not reflected in the findings below.

Respondent Demographics

The regional breakdown of the 491 individuals who responded to this question follows:



The self-identification of the 469 individuals who responded to this question follows:

Local health department	28%
Persons living with HIV/AIDS	22%
State/federal govt. employee	12%
Other HIV care provider	9%
Administrator	7%

Prevention provider	7%
Substance abuse/mental health provider	5%
Primary care provider	4%
HIV case manager	4%
HIV clinician	2%
KHPAC member	

"Stigma…people are afraid."

"Fear of the truth, being labeled."

Do you feel people are aware of HIV prevention and care services in your community?

Based on 380 responses to this question, there is a significant difference of opinion. Fully 41% of respondents replied that HIV prevention services are known, but another 59% indicated that HIV services are not well known. A number of issues were raised including denial of risk, lack of knowledgeable referrals from health care providers, and stigma.

If, NO, what gets in the way of individuals knowing about available resources?

Of the 222 responses to this question, many suggested that stigma was an overarching concern. This appeared to be embedded in responses from both urban and rural areas. "Ignorance," "lack of perceived risk," and HIV being perceived as a "Gay disease" were often cited as barriers. It appears that both homophobia and stigma of HIV play a significant role in individuals at risk not accessing services.

"Not being able to give HIV/AIDS awareness presentations and information in schools, church communities, prisons, and public forums."

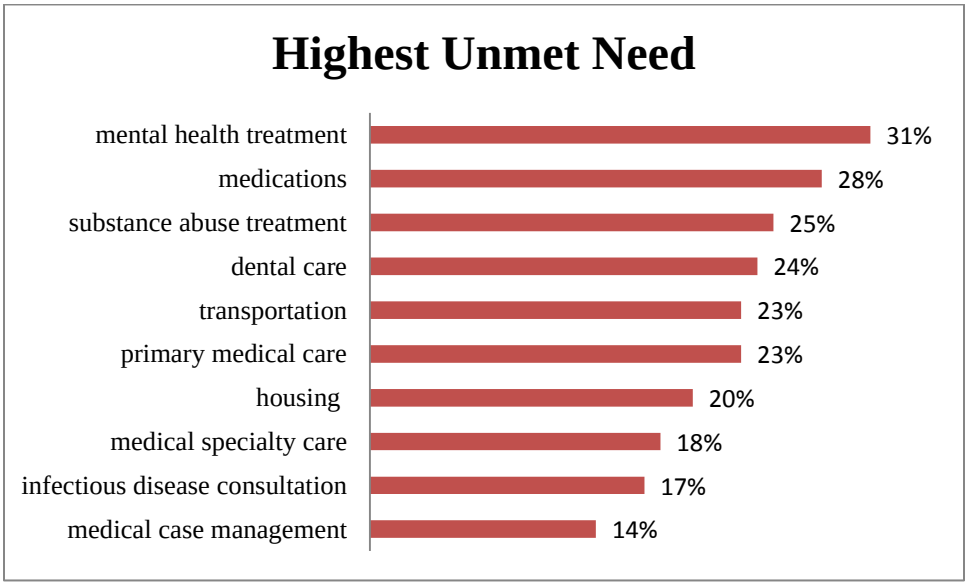
In addition to these issues, the survey yielded a number of concerns about funding for prevention activities. A significant percentage of respondents complained of reduced funding, limited funding, or mentioned services that were no longer available.

Another significant percentage of respondents spoke of difficulty finding/knowing about HIV testing facilities and prevention activities. These respondents spoke often about a need for enhanced media or publicity, suggesting that lack of public awareness could be altered by use of print, radio,

and television ads highlighting the fact that HIV is still a concern, not just a 'Gay problem', and that it was a local concern.

Which services are perceived most difficult for an individual with HIV to access in Kentucky?

Three hundred and eighty-seven individuals responded to this series of questions. Each respondent was given a list of services and asked to rate each service on a 4-pont scale ranging from "highest unmet need" to "need mostly met." Percentages noted in the table below reflect the amount of respondents who indicated that each specific service had the "highest unmet need" on this scale.



Nearly one-third of respondents (31%) indicated that *mental health treatment* was the highest unmet need, followed closely by *medications* (28%), *substance abuse treatment* (25%), *dental care* (24%), *transportation* (23%) and *primary medical care* (23%). Some participants suggested the following as "other" unmet needs: insurance, nutritional counseling, food pantries, life-skills educational workshops, financial assistance (utilities, rent, food, and medical supplies), support groups, vision services, and legal assistance (wills, discrimination claims).

How culturally competent are HIV prevention and care service providers in your community?

70% of survey respondents reported that local HIV prevention and care service providers were "culturally competent" or "very culturally competent."

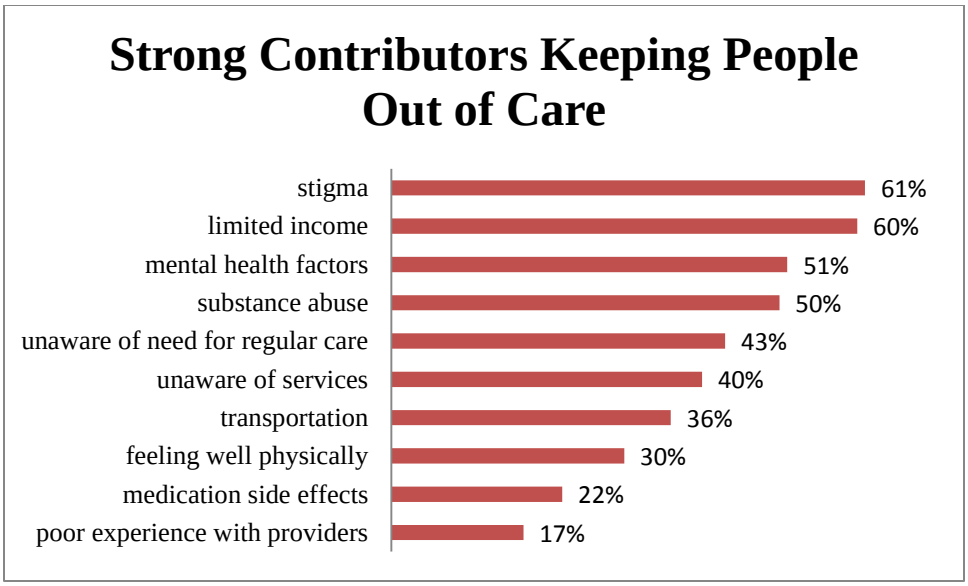
Of the 385 individuals who responded to this question, 70% indicated that HIV prevention and care service providers in their community were either "competent" (48%) or "very competent" (22%). This finding was noted to be all across the state with few regional differences in terms of the perceived cultural competence of the health care providers.

How significant a concern is confidentiality of health information for consumers in your community?

Of the 388 responses to this question, 71% indicated that confidentiality was a "very significant concern" (55%) or "concerning" (16%). The remaining respondents suggested that confidentially was "somewhat concerning" (17%) or "not concerning" (12%). This response is consistent with the overwhelming message in the survey that the stigma of HIV, fear of being "found out" as HIV positive in a community , and the difficulties keeping secrets in small towns are major barriers to be addressed.

We are very concerned about people who are aware of their HIV status but are not in care. Which of the factors below do you think contribute most to individuals being out of care in your community?

Three hundred and seventy-one individuals responded to this series of survey questions. Respondents were given a list of possible contributors, or reasons why people may be currently out of care. For each reason, respondents were asked to indicate, on a 4-point scale ranging from "strongly contributes" to "probably doesn't contribute," how strongly they thought each contributed to people being out of care. *Stigma* and *limited income* were both described as "strongly contributing" to individuals being out of care by roughly 3 out of every 5 respondents.



Some respondents offered "other" contributing factors not already listed in the survey question. These suggested factors include: privacy, lack of individual's commitment/ability to comply, fear of discrimination, fear of loss of control, low level of medical provider's experience in dealing with HIV+ clients, denial of infection, other life priorities (family, etc.), limited education, work stress, language, culture barriers, and lack of education.

Where do you see HIV care/support services overlapping or being duplicated in your community that should be streamlined?

Of the 196 responses to this question, an overwhelming majority of respondents said there are no overlaps in services—often citing the paucity of services as a counterargument.

Of those few respondents who listed an overlap, a few discussed overlap of case managers [especially Lexington and Louisville] and several spoke about the need for coordination of case management services. These comments took on two issues: need for elimination of dual case managers where that exists, and ability to share information between providers. The final issue raised about case management was a suggestion to co-locate all case managers in care settings.

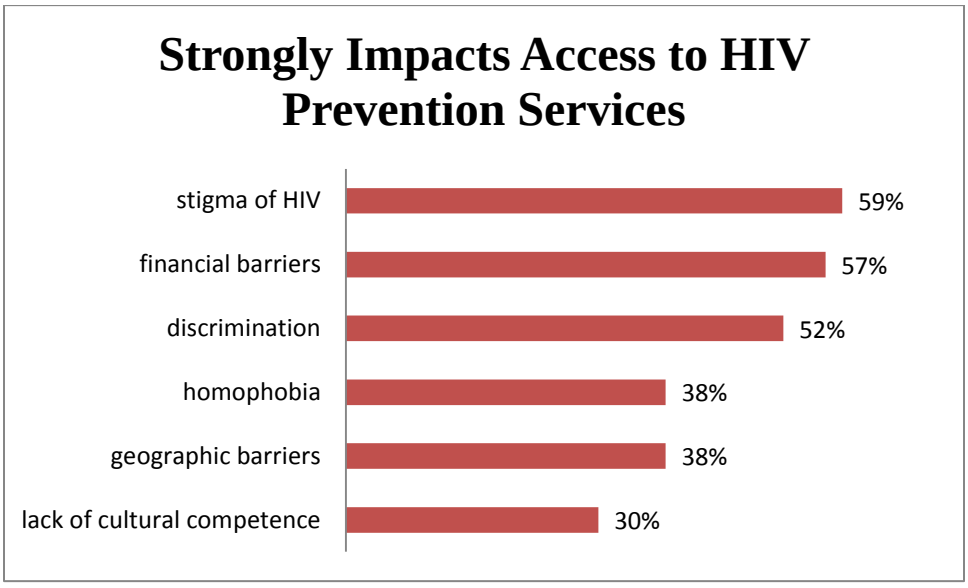
What else can be done to enhance the HIV care of people living with HIV in Kentucky?

Two hundred and twenty-two individuals responded to this question. From those individuals came the following suggestions:

- Enhanced and more diverse support services for PLWHA
- Increased education and public awareness
- Increased funding for services and prevention
- Help with funding for insurance, housing, and co-pays
- Training of health care providers; increased sensitivity of health care providers
- More substance abuse treatment
- Increased housing opportunities

Which of the following impacts individuals accessing HIV prevention services?

According to the 358 respondents to this question, three clear issues arose as "strongly impacting" access to HIV prevention services: *stigma of HIV* (59%), *financial barriers* (57%), and *discrimination* (52%).



We know that many individuals with HIV do not know their status because they have not been tested. Why don't individuals who need HIV testing access counseling and testing services?

Of the 361 responses to this question, nearly 1 in 3 responses (61%) indicated *stigma/discrimination* as the most likely reason for not accessing HIV counseling and testing. Nearly half of respondents (47%) indicated that *lack of perceived risk* was a highly likely reason for not accessing these services.

Additionally, some individuals suggested other likely reasons for individuals to not seek HIV counseling and testing services. These included: denial, lack of confidentiality in small towns, lack of free testing, testing not being a routine part of medical visits, fear of having to tell others/partners, language barriers, and the "KY tell policy."

What can be done to encourage HIV testing for those at highest risk?

Many varying suggestions to encourage HIV testing were offered by 251 survey respondents. Many dealt with how the test was offered. Issues of cost were common, and many survey respondents suggested free testing would be an incentive to increase testing. A number of individuals discussed the role of mobile testing, testing in non-healthcare sites, and "taking the test to the community" as ideas they felt would increase uptake of HIV testing.

> ***"Denial is easy. I had a partner who died in bed with me after denial of infection for years."***

A number of individuals were concerned about HIV testing in health care settings. Of those, many suggested enhanced training of health care providers; some proposed a more punitive approach to working with public sector providers who were not testing patients.

A number of individuals continue to emphasize the role of public information in increasing perceived risk and in mobilizing testers. There is also significant support expressed for continued anonymous testing. Probably rooted in issues of stigma, there appears to be a concern that eliminating anonymous testing could, in fact, mark a decrease in HIV testing.

STATEWIDE PRIORITIZATION PROCESS

The Needs Assessment Work Group met to conduct its prioritization activities regarding unmet needs and to advise the HIV/AIDS Branch on strategic priorities in addressing these gaps in prevention and care. At the Needs Assessment Work Group meeting (May 1, 2012), the planning body—representing stakeholders in prevention and care from across the state—discussed issues to be addressed, beginning with input on how to find HIV-positive individuals who were unaware of their HIV status. There was significant discussion on the role *stigma* plays in reaching individuals unaware

of their status. It seemed to be consensus that stigma, combined with a profound lack of information/awareness of risk, were the most significant contributing factors to poor uptake of HIV testing among vulnerable populations.

In addition, the following were identified as issues affecting individuals who are HIV-positive but unaware of their status:

- Residence [i.e. living in rural areas]
- Fear of being 'discovered'
- Lack of access to health care - especially rural regions
- Lack access to health care for Latino and immigrant workers
- Lack of perceived risk among older populations
- Lack of screening among people co-infected with HIV and hepatitis/STIs
- Limited perceived risk among young black MSM despite prevalence

The Needs Assessment Work Group offered a number of suggestions to address some of the barriers. One suggestion raised was attempting to *increase adoption of CDC guidance on routine testing* in health care settings. It was believed that a number of individuals have been missed in the health care settings and that an enhanced effort to conduct routine screening would net a significant percentage of people who have HIV and not aware of their status.

In addition, there were a number of compelling suggestions regarding *community-level interventions* to prevent HIV that were shared. The group felt that interventions to change community norms and perceptions of risk would be helpful in impacting populations not currently aware of their status. In addition, a number of suggestions for finding individuals unaware of their status were suggested. These included:

- Enhance collaborations/identify 'Gatekeepers' in communities
- Use social media and technology better
- Customize prevention efforts; state should set clear 'goals or targets' then allow agencies to determine how to achieve those goals/targets
- Collaborate with community partners on 'general health screening' to make sure that health screening is bundled with other health screening activities
- Increase condom distribution
- Implement comprehensive positive prevention interventions
- Increase access to testing/linkage to care

- Propose policy initiative in favor of comprehensive sexual health education for 8th graders
- Increase collaboration between STD/HIV-not just locally
- Expand non-traditional partnerships [e.g. churches]
- Maximize use of CBOs and Federally-qualified health centers
- Implement peer to peer counseling
- Initiate aggressive interventions in schools, particularly targeting Black male MSM
- Conduct media campaigns [similar to recent anti-smoking campaigns to enhance perceived risk]
- Implement online interventions
- Implement testing in hospital emergency rooms; building capacity of primary care and ID docs along HIV treatment psychosocial treatment
- Build capacity of testing agencies to provide FREE confidential testing and counseling technique that will help increase uptake of confidential [i.e. not anonymous] testing

Another important discussion at the Work Group meeting was identification of unmet needs or gaps in services for individuals who are *aware* of their status. Globally, access to HIV care, medications and medical case management appear to be the strongest consistently met needs. Beyond these, significant gaps seem to exist statewide. *Access to primary [i.e. non-infectious disease] care* seems limited in much of the state and often, HIV care providers are the only resource for primary care needs.

In addition, *access to mental health and substance abuse services* appears to be a significant gap across the state. Lack of access to these supportive services appears to be complicating efforts for medication adherence and retention in care. In many parts of the state, access to multiple medical subspecialties appears to be a problem. While these vary somewhat by region, a clear picture emerges that Ryan White consumers—especially outside Louisville and Lexington—face substantial challenges accessing many medical specialties not available in their medical home.

Finally, issues of *geographic access* are pronounced challenges for individual with HIV in Kentucky—particularly in Eastern and Western regions. These complicated issues include the geographic distance to health care providers, issues of stigma and perceptions of confidentiality being compromised, and reluctance on the part of health care workers to treat individuals living with HIV. It appears that this reluctance is rooted in part in economic concerns [i.e.

poor reimbursement], but an additional part of this may be community perception of health workers treating HIV. A number of individuals suggested that treating HIV patients could be perceived as a disincentive for others in the community to seek care from that provider.
In addition, a number of global issues were suggested by members of the Work Group. These included:

- Lack of specialty care
- Lack of substance abuse treatment
- Challenge of finding primary care providers for consumers without insurance
- Lack of Housing, transportation
- Lack of Hepatitis C treatment for co-infected individuals
- Lack of funding for non-HIV medical expenses
- Lack of insurance coverage and inability to pay for premiums
- Lack of availability of a statewide comprehensive service directory
- Abundance of mental health concerns
- Lack of affordable and decent housing
- Lack of transportation
- Inability to fulfill basic needs due to poverty
- Lack of Infectious Disease doctors
- Lack of safe, social outlets for support
- Abundant amount of time needed for someone newly identified to get into care

Members of the Work Group next met in regional groups to identify some of the unique gaps in services for individuals living with HIV in their part of the state. These issues, prioritized by regional representatives, are outlined below:

Lexington

- Lack of transportation
- Lack of primary care and education to outlying areas
- Lack of substance abuse treatment
- Lack of providers for uninsured patients

Louisville

- Too few providers [Infections Disease physicians]
- Lack of insurance coverage
- Lack of substance abuse treatment
- Lack of affordable and safe housing
- Lack of HIV primary care for indigent patients

- Lack of substance abuse treatment for indigent patients
- Lack of effective transport from rural areas

Eastern KY

- Lack of transportation
- Lack of primary care for uninsured patients
- Lack of substance abuse treatment

Western KY

- Lack of primary care and specialty care
- Lack of substance abuse mental health treatment
- Lack of transportation
- Lack of primary care providers for uninsured
- Lack of Hepatitis C treatment for those co-infected
- Lack of insurance

There was discussion among the Work Group about duplication or overlap of services. Overall, there was widespread agreement that, for the most part, there are few duplicated services and that the much larger issue in Kentucky was accessing needed services. Still, a few opportunities to consolidate resources or enhance collaborations were proposed. These suggestions included:

- Comprehensives HIV and service provider list serve
- 'One Stop shops' with MOAs and negotiated prices for services in place
- Use of Physician Assistants and Nurse Practitioners especially in rural areas

The Work Group turned attention to the issue of retention of individuals in care or challenges with linkages to care. There was strong feeling that *stigma* and *perceived discrimination* were central reasons why individuals with HIV did not access or stay in care. In addition, *economic concerns* and multiple other *issues of access* appear to be significant barriers to retention and linkage into care. Finally, poorly managed pre-morbid *mental health and substance abuse* were often cited factors contributing to challenges with both linkage to care and retention in care.

The following are further suggestions about issues to be considered and addressed, if possible, for individuals not in care:

- Cost of care
- Other life priorities
- Pill fatigue

- Lack of insurance
- Relocation - unsure of available services in the new area
- Feeling fine
- Length of time to get an appointment
- Homelessness
- Services being ‘too far away’
- Lack of transportation

There were multiple suggestions for enhancing linkage to care and retention in care. These are listed below:

- Promote ‘Peer to Peer’ linkage
- Utilize field notification—using DIS to reach individuals out of care
- Provide continuing education for health care workers
- Promote individual accountability
- Test and link [short-term follow-up support for newly diagnose individuals]
- Establish a network of service providers
- Offer mini-grants for linkage programs [non-traditional partner collaboration]
- Retain staff members
- Use prevention staff as a link to ‘draw back’ individuals into care
- Use good customer service
- Apply effective tracking service to keep individuals in care
- Expand Care ware database so case managers can view other facilities databases and patient contact information
- Invest in linkage to care activates that are comprehensive and collaborative
- Use DIS workers to do tracking and follow up on persons out of care
- Enhance health literacy
- Address social determinants of health, particularly for females in rural settings
- Use text message alerts for medical appointments and medication times
- Continue education for consumers

These suggestions—and all input from stakeholders—will be evaluated and will factor into the planning process for HIV prevention and care activities of the HIV/AIDS Branch. The Branch is grateful for the wise counsel and commitment of the Kentucky HIV/AIDS Planning Committee and the individuals and organizations who supported the needs assessment activity.

PREVENTION PRIORITIES

As part of the statewide prioritization process, a group of prevention providers and consumers met to determine what should be the priorities for HIV prevention activity. The initial discussion involved an exploration of the barriers for HIV testing for individuals unaware of their status. As in other areas of the assessment, stigma was seen as a major barrier to testing, and a significant concern was expressed about lack of perceived risk and community awareness of HIV as a problem. In addition, the following were seen as important factors in why individuals who are unaware of their status are not testing:

- Poor access to medical care
- Office hours not 'user friendly'
- Transportation
- Stigma of a state car
- Language barriers
- Cultural barriers-uncomfortable with homosexuality, sexuality, emphasis on 'machismo'
- Issues for young MSM
- Slow response from churches
- Co-occurring mental health/substance use issues
- Issues for refugees – language, fear of deportation
- Perception that HIV is 'no big deal'
- Medical providers not offering HIV as a matter of routine care

The group proposed a number of strategies to enhance acceptance of testing. The primary focus was on increasing access by making testing more accessible. Strategies suggested included increased use of mobile testing, offering HIV testing in correctional and substance abuse treatment settings, routinely offering testing at community health events, and outreach on college campuses. Additional suggestions for increasing testing to identify those individuals who are positive and unaware of their status included:

- Specific marketing initiatives to 'down low' men/using MSM as 'gatekeepers'
- Stress impact of not knowing status on family
- Market testing by emphasizing access without needles/sell convenience of testing
- Increased sensitivity to transgender issues
- Increase use of technology/social media

- Use waiting times [e.g. consulate events] to offer HIV testing
- Empowerment of women
- Online prevention

When asked to review previous prevention activities which had been successful, there was a strong shared belief that culturally and linguistically competent outreach into communities had resulted in effective information exchange and helped link people to prevention services. Examples of these included peer education in correctional settings, safer sex parties, church fairs and health fairs, as well as targeted recreational events where HIV testing was offered.

Other activities which had been conducted and were seen as having made an impact include:

- Specific prevention specialists as focal points by risk behavior
- Collaborations with hospitals
- Providing child care at prevention events
- Internet outreach/campaigns
- Spanish language print media/interviews on radio
- Incentives for HIV testing including food
- Collaborations with non-traditional partners

When asked about past HIV prevention activities that weren't successful, the group shared concerns about lack of success in implementing Diffusion of Evidence-Based Interventions [DEBIs]. The feeling was the lack of implementation success was connected to lack of sufficient economic support for delivering the interventions. There was agreement about the need to increase HIV testing opportunities in highest prevalence populations—using surveillance data to target HIV testing activity. In addition, need to increase testing and outreach in general and specific outreach to Latino communities were identified as emerging needs.

Additional suggestions for increasing HIV prevention included the following:

- Decrease time for training for test counselors [4-day course is too much]
- Increase local input on policy initiatives
- Increase KPHAC visibility/inclusivity
- Incorporate sexual health into school settings
- Talk to parents about how to talk to their teens

The final recommendations were focused on a discussion of high-impact prevention activities [as defined in the latest CDC guidance] and an exploration of which were especially relevant in Kentucky. The group focused on policy changes including advocacy for syringe exchange and enforcement of opt-out HIV testing in health settings.

In terms of enhanced collaboration, suggestions included increase collaboration between care and prevention and using social networks of individuals with HIV to target testing. Finally, it was suggested to increase behavioral interventions with additional resources/support [e.g. POL in many communities].

The input and suggestions put forth by stakeholders through this process will be considered and incorporated into the planning process of future HIV prevention and care activities of the HIV/AIDS Branch. The Branch is grateful for the candid and comprehensive insights shared by prevention providers, consumers and others who supported this needs assessment activity.

Care and Prevention Planning Efforts

Since 1994, the planning efforts of the HIV/AIDS Branch have been guided by the collaboration of the Kentucky HIV/AIDS Planning and Advisory Council [KHPAC]. KHPAC is a 30-member body appointed by the governor to carry out the provisions of KRS 214.640, the Centers for Disease Control and Prevention HIV Prevention Community Planning Guidance, and the Health Resources and Services Administration Planning Bodies Manual.

KHPAC—now also identified as the HIV Planning Group [HPG]—collaborates with the Kentucky Department for Public Health in a process referred to as the Jurisdictional Plan Development. The HPG has been populated to represent the diversity of HIV-infected populations and to make certain that other key stakeholders in HIV prevention and care have been brought to the table. The HPG meets at least quarterly and more often as business arises.

The Jurisdictional Plan Development assures a results-oriented engagement process in which the goal of seamless access to a continuum of care and prevention services is achievable. The HPG is also a principal partner in planning statewide meetings intended to bring together stakeholders outside the planning group, with broad and diverse perspectives on care and treatment needs, to advise and provide input into HIV prevention and care planning. In addition to more formal collaborations, the HIV/AIDS Branch staff maintains ongoing contact with KHPAC members to assist with document review, policy discussions, and strategic planning to enhance shared goals.

The Jurisdictional Plan [see next section] includes a description of existing resources, outlines unmet needs and gaps in services, and outlines prevention activities to be undertaken. This Plan aims to increase coordination of all HIV providers throughout the state resulting in a reduction in HIV infection across the state. In addition, the HPG oversees a process of creating of a Comprehensive Program Plan which describes in detail the plan for addressing the gaps and needs identified in the Jurisdictional Plan.

The HPG's core members consist of the health department co-chair [representing the HIV/AIDS Branch], two community co-chairs, and representatives who allow the group geographic and racial/ethnic diversity maintaining commitment to the goals of parity, inclusion, and representation. Representatives include individuals living with HIV/AIDS, health care workers, case managers, prevention providers, faculty of universities in Kentucky, and individuals with experience in health policy, behavioral science, and epidemiology.

The Kentucky HIV/AIDS planning and Advisory Council (KHPAC) Engagement Process

HIV prevention in Kentucky takes place in a range of traditional and non-traditional settings as seen in the section titled, *Description of Existing Resources*.

Strategies for increasing coordination across HIV programs (i.e., prevention, care, and treatment) across the state, jurisdiction, and tribal and local governments to reduce rates of new HIV infection.

Steps for engagement should include: determining the goals of the plan and who to engage; developing engagement and retention strategies for previous partners; developing engagement strategies for new partnering agencies; prioritizing engagement activities; creating an implementation plan; monitoring progress; and maintaining the partner relationships.

ENGAGEMENT PLAN: The focus will be on assuring a results-oriented engagement process by exploring partnerships outside the current planning group, develop new collaborations, and review elements in the Jurisdictional HIV Prevention Plan to evaluate whether they are in place and effective. The Kentucky HIV/AIDS Planning and Advisory (KHPAC) Council will engage stakeholders infected and affected by HIV/AIDS in providing guidance to the Commonwealth of Kentucky about the community's perspective on the state of HIV/AIDS and responses and resources required.

KHPAC's Engagement Plan will begin with an immediate recruiting effort to form a committee of up to 30 representatives from the following constituencies:

- People living with HIV/AIDS
- Physicians and medical support staff
- Dentists and dental support staff
- Hospital representatives
- Pharmacists
- Pharmaceutical company representatives
- Teachers, school counselors, school boards, parent-teacher associations, and representatives from the department of education
- Volunteers to work with AIDS Service Organizations.

University representatives/ Researchers

- Student government and organizations/ fraternities/ sororities
- Nursing home representatives
- Kentucky Primary Care Association
- Care Coordinators
- Prevention/Outreach workers
- Members of high-risk populations
- Local lawmakers/ government representatives
- Religious leaders
- Representatives of the African-American and Latino communities
- Local housing authorities/providers
- Mental Health providers
- Substance Abuse treatment providers
- Immigration experts- undocumented/ refugees

- Health Advocacy groups
- Teachers and guidance counselors
- Fairness organization representatives
- Department of Health representatives
- Department of Education representatives

Immediate goals of the Engagement Plan are a Marketing/PR plan for recruitment and networking. KHPAC will collaborate with the Health Department to utilize statewide communication networks to explain the role of KHPAC and to encourage involvement. Recruitment efforts may include public hearings, information sessions held in different geographical areas of the state, surveys, phone calls and personal meetings.

The group envisions two roles for participants: Advisors and Work Group Members. Advisors will lend high-level expertise and perspective while Work Group Members will produce the various products of the council.

KHPAC each year will compile and prepare, with input and collaboration from the Health Department and other stakeholders, a Community Advisory Plan for HIV/AIDS in the Commonwealth of Kentucky. This plan will serve as the community's point of reference when responding to the activities of the state.
Benchmarks for measuring the progress of the Engagement Plan will include:
 monitoring the number of recruitment contacts made for Advisors and Work Group members
 hosting trainings for existing and new KHPAC members
 holding quarterly meetings to rotate geographically throughout the state
 requiring Advisors and Work Group Members to agree to accountability standards to ensure the sustainability and effectiveness of the planning group

The Jurisdictional Plan and the Comprehensive Plan strive to address unmet needs and gaps in prevention services identified. The following description represents the key activities in the Jurisdictional Plan for Kentucky. These key activities represent the HIV/AIDS Branch's commitment to high-impact prevention activities and to implementing interventions which can reach affected populations on a large scale. The specific activities and evaluation plans for achieving the aims of the Jurisdictional Plan are outlined in the next section of this document, the Comprehensive Plan. As part of the JHPP, the community planning group, KHPAC, plans to recruit volunteers to work with AIDS Service Organizations in order to provide supplemental human resources, address gaps and conduct activities that are no longer be funded by the state and the federal grant, such as prevention and testing activities in unfunded zip codes in urban areas and within the rural areas.

These high-impact prevention activities focus a majority of efforts on targeting activities to those individuals unaware of their status and those who are HIV-negative and at highest risk. Highlighted activities to be included in the FY 2012 plan are:

- HIV Testing Activity - The focus of this activity will be on reaching individuals living with HIV who are not aware of their status through a continued collaboration with health departments and enhanced HIV testing in non-healthcare settings. The Health Department will continue to collaborate with funded agencies to identify those individuals most at risk; support targeted testing, monitor positivity rates to ensure return rates > 1% HIV prevalence.

- Condom Distribution - This goal is to be implemented by targeting most vulnerable populations and improving access to condoms. Ongoing support for ordering, tracking, monitoring utilization and evaluation of distribution activity will be in place. The focus will be on finding Kentuckians with poor access, providing community accepted brands of condoms, and combining distribution plans with social support for changing norms about condom use.

- Policy Initiatives - The intended policy activity will focus increasing HIV testing in KY correctional settings. This activity is believed to result in identification of individuals unaware of their HIV status. KHPAC will work with the HIV/AIDS Branch and the Kentucky Department of Education to develop and implement a policy for incorporating comprehensive sexual health education in school settings, particularly for 8th graders and a requirement for annual reporting to the state by schools regarding which classes have incorporated comprehensive sexual education as contained in the Kentucky Core Academic Standards and the types of resources being used. In addition, KHPAC will work with the Kentucky Department of Education and the HIV/AIDS Branch to assist schools in developing initiatives that build parental knowledge and skills and facilitate effective parent-child discussions around sexual health.

KDPH will continue to propose mandatory testing of pregnant women. A bill revising KRS214.160 to mandate HIV testing of pregnant women in Kentucky was proposed by KDPH to be included in the Cabinet's 2008, 2009 and 2012 gubernatorial packet of favored legislation. The bill aims to include HIV in the battery of tests mandated for all pregnant women and follows the recommendations of the 2006 routine testing guidelines as it pertains to testing of pregnant women, including re-offering testing in the 3rd trimester. The revision of KRS 214.160 will allow Kentucky's law to match standard practice for the treatment of pregnant women. The current version of the law requires testing for HIV, syphilis and toxicology testing. By adding testing for Chlamydia, gonorrhea and Hepatitis B, more women can be treated for conditions that may not readily manifest symptoms and cause harm to both mother and unborn child. Toxicology testing would be altered to include possible investigation into child abuse or neglect. These revisions would enable the Department for Public Health to be on the forefront of care for Kentucky's unborn children. It will also enable better surveillance in the HIV/AIDS and Infectious disease branch by possibly identifying those who may not otherwise be tested. Better surveillance allows for more accurate representation of the populations affected by these various diseases in annual reports and publications. KDPH will continue to propose this bill with the support of pertinent partners until such time that it is enacted. The work to push this bill and other HIV testing policy

will be done in conjunction with pertinent partners including KHPAC and the Association for Professionals in Infection Control and Epidemiology (APIC)- an organization with over 13,000 members and three chapters in Kentucky.

KDPH has been and continues to work with health care providers to promote routine, universal HIV screening of all pregnant patients early in pregnancy; and works with organizations and institutions involved in prenatal and postnatal care for HIV-infected women to ensure that appropriate HIV prevention counseling, testing, and therapies are provided to reduce the risk of transmission. All health care workers licensed in Kentucky are required by law to have continuing education on HIV/AIDS each licensure period. This continuing education includes the recommendations for opt-out testing of pregnant women, and perinatal prophylaxis recommendations. Additionally, Family Planning at local health departments provide opportunities for counseling and testing. It is Kentucky's policy to educate every pregnant woman on the importance of HIV testing and to recommend taking a test. However, testing is optional. As stated in the Kentucky Public Health Practice Reference, a pregnant woman who receives prenatal care through the local health department system will be counseled on HIV, including identification of risk factors and risk reduction methods. Regardless of risks, initial prenatal HIV testing is recommended, but not required. Patient's informed consent is obtained before receiving an HIV test, but has a right to refuse testing. Refusal of the HIV test at the initial visit or at the recommended retesting time frame for those individuals at risk should also be documented in the medical record. KDPH is committed to providing additional prevention and health educational materials and training to all providers in local health departments, in addition assessing the needs for improving provider/client communication and routine prenatal HIV testing.

Currently, 902 KAR 2:020 section 7 pertains to HIV testing and what information is to be reported to the HIV surveillance section. As written, it requires that all laboratories send CD4 results and detectable viral loads. Currently, revisions are being made to this regulation to require all viral loads to be reported to the HIV surveillance section. This revision will coincide with current actual practice, in which the KY HIV surveillance branch routinely receives all viral loads regardless of detectable status.

Each year, KHPAC presents an annual report to the state legislature highlighting issues that are of pressing concern from a policy or funding perspective. While KHPAC does not advocate for specific items of legislation, the committee does provide education to legislators about the complex issues surrounding the HIV/AIDS epidemic in Kentucky. In addition to this annual report, representatives from KHPAC usually make a presentation to the Kentucky legislature's Interim Joint Committee on

Health and Welfare in advance of each year's legislative session. Issues addressed in KHPAC's annual report and legislative presentations have included:

- The Kentucky AIDS Drug Assistance Program (ADAP) funding and waiting list.
- Enforcement of comprehensive science-based sex education laws already in place.
- Maintaining the priority of HIV/AIDS education for health professionals.
- Advocating for voluntary inmate testing upon entry and before release from any unit governed by the Department of Corrections.
- State funding for HIV surveillance
- Anticipated impacts on Kentucky's HIV/AIDS prevention and care efforts arising from changes to CDC, Ryan White, HOPWA, and other federal sources of HIV/AIDS funding
- HIV/AIDS education, outreach and testing in state-sponsored substance abuse treatment centers
- Collaborative efforts between the HIV/AIDS and STD branches of state government

- Comprehensive Prevention for Positives - This strategy will focus on use of Disease Investigators to identify and locate individuals with confirmed HIV tests who did not seek care after their initial referral. These individuals will be linked to community-based organizations that can provide intensive support for treatment adherence and risk reduction. In addition, DIS will locate individuals who are aware of their status who have not remained in care and link them to case managers who will work more intensively to retain them in care.
- Monitoring and Evaluation - The plan for enhanced M & E will include more regular site visits from HIV Program staff. Please see the comprehensive table of goals and objectives and monitoring and evaluation plan in the upcoming pages.

Comprehensive Program Plan *"PROGRAM PLAN"*

Kentucky plans to Meet 2009 Challenges Identified in 2009 Comprehensive Plan with performance measures, goals, objectives and effective strategies to address the barriers to care needs and gaps in services that have been identified. The priority challenges identified as needing additional attention for the Comprehensive Plan are broken down into the following categories:

1. Kentucky AIDS Drug Assistance Program (KADAP): Develop & implement educational tool guide for case managers & clients. (i.e., revise KADAP manual with updated policies and procedures, interactive web presentations, provide adherence education, and quarterly trainings for all case managers).
2. Correctional Initiatives: HIV education, testing and linkage to care and treatment services Kentucky Part B, Prevention & Department of Corrections to collaborate on development & implementation of a targeted HIV education, testing & linkage to care services pilot project during the initial intake process of inmates. This is an ongoing focus of Kentucky as the Part B program continues to address legislature.
3. Discharge Planning Develop and Implementation: A Discharge Planning Pilot Program at LaGrange State Correctional Facility, which houses the largest number of HIV+ Inmates in Kentucky – ongoing.
4. Transportation: The Part B Program has significantly curtailed transportation costs and barriers to care by funding medical case management and providing support for a medical clinic in the Cumberland Valley District Health Department. This has decreased travel for clients of this area more than 3 hours each way and allowed more than 100 clients to stay in the region which they live for medical care.
5. Collaborations (Internal DPH Collaborations and the Departments of Medicaid and Medicare Services): The Part B and Prevention Services has convened an internal Department for Public Health Task Force of relevant staff members from the HIV/AIDS Branch, the Sexually Transmitted Disease Program, the Tuberculosis Program, the Maternal and Child Health Program and the Office of Health Equity to identify areas of collaboration as well as incorporate outlined processes into the operating procedures and policies of applicable programs to amplify service outreach and education impact.
6. Cultural Competency: The Kentucky Part B Program has increased provision of cultural competency trainings as well as conducting activities to improve and enhance links and services to African American and Hispanic Communities through our Non-Traditional Partners Program. This program targets identified populations through outreach and education to remove HIV+ persons by removal of barriers to care and enrolling those eligible to the Kentucky AIDS Drug Assistance Program (KADAP).

7. Provider Education: The Kentucky HIV/AIDS Branch to Medical Case Managers and to utilize the AETEC program in Kentucky.
8. Oral Health: The Kentucky HIV/AIDS Branch continues to work with Ryan White Part F clinics throughout the state to link eligible clients to oral health care.
9. Quality Management: In 2012, Kentucky performed a comprehensive clinical quality management site visit to each Part B funded contractor. These results of these site visits will be used as a benchmark for the subsequent site visit in 2013.
10. Disenfranchised Group (Mental Health, Substance Abuse, Homelessness, African Americans, and Hispanics): Kentucky continues to work with sub-grantees to develop a service program that is used to educate and provide technical assistance for staff to reach this disenfranchised group.

The plan includes program planning (goals, objectives, and activities), monitoring and evaluation (M&E), quality assurance (QA), and capacity building activities specific for PS12-1201. Guided by the Needs Assessment Committee and engaged with KHPAC, the four goals and associated objectives and activities presented on the following pages represent an attempt to capture the unmet needs and challenges documented in the needs assessment process and create solutions to address those unmet needs, in alignment with the national HIV/AIDS strategy (NHAS). While certain problems may not be solved in the near term, the Branch is committed to its ongoing mission of high quality core medical services delivered by sensitive providers in proximity to individuals' home communities.

At this time, it is important to note that the activities in these goals and objectives will primarily be carried out by the Part B staff. The staff in the Part B office oversee ADAP, Care Planning, Monitoring & Evaluation, and Quality Assurance processes. In addition, activities which require linkage to care and prevention in HIV care settings will utilize the existing partnerships within the Branch and the Care and Prevention teams.

The Prevention unit works closely with a number of subcontract agencies who provide counseling and testing, condom distribution, partner notification, and risk reduction education. These subcontractors provide the HIV Branch access to communities at highest risk which might not be accessible if not for the community collaborations. To that end, the Prevention unit plans to enhance its community partnerships with a number of 'non-traditional' provider contracts. These

contracts allow the Branch to provide high quality HIV testing and health education in communities with high HIV prevalence—and impact of disparities.

COMBINED GOALS AND OBJECTIVES

GOAL 1: REDUCE NEW INFECTIONS IN HIGH INCIDENCE AREAS

Priority: Need to identify individuals unaware of their HIV status.			
	Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective1a: By 12/31/13, increase HIV tests in targeted high risk populations in non-clinical settings and at events to at least 8050. **Objective 1b: By 6/30/2013, achieve at least a 1.0% rate of newly-identified HIV-positive tests annually for targeted HIV testing in non-healthcare settings or venues.** **Objective 1c: By December 31, 2015, reduce the proportion of late diagnosis by 10%.**	How many HIV tests were conducted (Men who have sex with men (MSM), Intravenous Drug Users (IDU), High Risk-Heterosexuals (HR-HET), Other/Unknown, African American (AA), Hispanic (Hisp.), Other/Unknown) within non-clinical settings stratified by high risk populations? Number of HIV positive tests in community settings for the 12-month measurement period? Are new positives being identified?	*EvalWeb*	Data from *EvalWeb* will be analyzed monthly to determine the number of tests performed in non-clinical settings. Bench mark assessments of reported CD4 and Viral load within 3 months of diagnosis

		Number of persons with a diagnosis of Stage 3 HIV infection (AIDS) within 3 months of diagnosis of HIV infection in the 12-month measurement period.		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
KDPH provides prevention contractual agreements with various selected community-based organizations within the jurisdictions of Louisville Metro, Lexington-Fayette County, Warren County, and Kenton County to provide targeted testing to communities with high risk individuals in the zip codes with highest HIV incidence and prevalence.	07/01/2012 – 06/30/2013	What proportion of contracts has been executed? What proportion of sub-grantees provides services in the highest prevalence zip codes? What proportion of sub-grantees has fully implemented all elements of the scope of work of their contracts? How many tests were conducted per funded agency?	*EvalWeb*	Benchmark assessment of implementation of each agency's contractual scope of work. Benchmark assessment of the number of tests conducted per contracted agency.
Contracted community-based organizations (CBOs), and contracted non-traditional partners will receive Technical Assistance, training, and Grantee Orientations, around the specific zip codes and	07/01/2012 – 06/30/2013	What proportion of sub-grantee s participated in orientation, training, and TA? Has technical assistance been provided?	-Online Databases will be created (e.g. Google Docs) that keeps track of online trainings given	Online Databases will be implemented and employed to keep track of technical assistance (TA) requests and completed TA trainings. Pre- and post-test surveys to evaluate skills building and

areas, as well as venues to target high risk individuals for targeted HIV Testing.			for TA -HIV testing data	knowledge improvement of staff.
Contracted CBOs and non-traditional partners will conduct community assessment to identify and conduct testing at venues frequented by the target population in the zip codes of high prevalence as well as venues outside of the zip code where there is occurrence of risky behavior by social networks of HIV positive persons.	07/01/2012 – 06/30/2013	What proportion of the contracts funded have testing services established in venues for high risk populations within the zip codes of highest prevalence and/or within social networks of HIV positive persons? What is the seropositivity for each funded agency? What is the overall seropositivity rate of testing in community settings/	Site Information Worksheets and Participant Feedback	Bench mark assessment of seropositivity rates for each testing venue per agency.
KDPH will facilitate training, technical assistance, and capacity building on social network recruitment strategies for all sub-grantees funded to conduct HIV testing.	12/30/2012	What proportion of sub-grantees received training, TA and CBA?	CDC CRIS database. CBA Provider NMAC data base of participant surveys	Training certified by CDC? Pre- and post-surveys conducted to evaluate skills building of sub-grantees.
Implement social networking strategy initiatives for targeted populations in Jefferson County and Fayette County.		Are target populations being reached? What is the message being delivered to the target populations?	EvaluationWeb	
KDPH will provide small funding	06-01-2012 to		*EvalWeb*	Test forms submitted to

and 1,000 HIV tests to be conducted by community-based organizations through mini-RFPs for various National HIV/AIDS Awareness and Testing Days.	06/30/13	How many events were funded through mini RFPs for Awareness Days? How many persons participated in events? How many tests were conducted at HIV/AIDs Awareness Days? What proportion of those tested were newly diagnosed persons were identified through mini-RFPs for Awareness days?		prevention with dates and site type will be analyzed to determine the number of tests conducted on specific HIV/AIDS awareness days. Bench mark assessment and evaluation of number of funded events, number of participants, and proportion of newly diagnosed.
KDPH will provide small contractual grants for non-traditional partners, located in communities with individuals at high risk, to provide specific targeted testing.	06/01/2012 - 06/30/2013	Have non-traditional partner grants been executed?	*EvalWeb*	Request for Proposal released; contracts will be awarded to successful bidders. Site visits and audits on a monthly basis. Ongoing technical assistance and capacity building.
Contracted community-based organization will enter monthly testing data. KDPH staff will enter data from non-contracted testing sites and all local health departments.	Monthly & ongoing	How many agencies have entered all their required data for the period?	*EvalWeb*	Quality checks will be conducted periodically to assess whether contracted community-based organizations are entering data in a timely fashion. Assessment of data completeness and cleanliness.
KDPH will monitor testing data entered submitted by community-based organizations and local	Monthly & Ongoing	Has data been entered correctly?	*EvalWeb*	Quality checks will be conducted periodically to assess the accuracy,

health departments to evaluate Targeted Testing Strategies.				completeness, and cleanliness of data entered by the contracted community-based organizations. If there are consistent inaccuracies in the data, training on entering the data will be provided.
Implement and/or coordinate HIV testing in non-healthcare settings to identify undiagnosed HIV infection using multiple strategies and the most current recommendations for HIV counseling, testing and referral. Support HIV testing activities in venues in the zip codes with the highest incidence to reach persons with undiagnosed HIV infections.				

Priority: Need to identify individuals unaware of their HIV status.			
	Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 2: By 6/30/2013, at least 12,000 HIV tests will be conducted in clinical settings. **Objective 2b: By 6/30/2013, achieve at least a 2.0% rate of newly-identified HIV-positive tests annually for healthcare settings.**	How many newly diagnosed HIV positive persons have been identified in clinical settings? Number of HIV positive tests	*EvalWeb* eHARS	Bench mark assessment and evaluation of number of newly diagnosed persons.

		in health care settings for the 12-month measurement period?		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Implement and/or coordinate opt-out HIV testing of patients ages 13-64 in healthcare settings.	06/30/2014			
KDPH provides prevention contractual agreements with Local Health Departments in the Highest HIV Prevalent jurisdictions of Louisville Metro, Lexington-Fayette County, Warren County, and Kenton County to provide targeted testing to communities with high risk individuals.	10/01/2012	How many agreements with health departments been executed? What proportion of funded health departments has implemented scopes of work to guide health department staff activities?	Original copies of the signed agreements	Site visits and audits to local health departments funded for HIV prevention and testing. Bench mark evaluation of implementation of the specific elements of the scope work for each funded health department.
Contracted Local Health Departments will receive Technical Assistance, during sub-Grantee Orientations, around the specific zip codes and areas, as well as venues to target high risk individuals for targeted testing programs.	12/31/2012 and Ongoing	Has technical assistance been provided? How many local health departments participated in orientations and received technical assistance and training?	Online Databases HIV testing data	Online Databases will be implemented and employed to keep track of technical assistance (TA) requests and completed TA trainings. Pre- and post-test surveys to evaluate skills building and knowledge improvement of staff.
KDPH will receive monthly HIV testing forms from clinical settings and local health	Monthly, Ongoing	Have testing forms been received?	Online Databases HIV testing data	Online Databases will be implemented and employed to keep track of technical

departments to determine the number of newly diagnosed individuals, as well as number of test performed.				assistance (TA) requests and completed TA trainings.
Contracted Health Departments will enter monthly testing data into *EvalWeb*.	Monthly, Ongoing	Has HIV testing data been entered?	*EvalWeb*	Quality Checks will be conducted periodically to assess whether contracted Health Departments are entering testing data in a timely fashion.
KDPH will monitor testing data entered submitted by clinical settings and local health departments to evaluate Targeted Testing Strategies.	By 12/31/2012 and Ongoing	Has HIV testing data been entered appropriately?	*EvalWeb*	Quality checks will be conducted periodically to assess the accuracy of data entered by the contracted health departments. If there are consistent inaccuracies in the entered data, training on entering the data will be provided.

Priority: Need to assure HIV positive individuals receive their HIV test results.			
	Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 3: By 6/30/2013, at least 85% of positive test results performed in clinical settings will be delivered within 30 days. **Objective 3a: By 9/30/13, assure that 90% of HIV positives are interviewed (post-test counseled)**	Have confirmatory tests been conducted and have results been delivered? What proportion of tests conducted were delivered	*EvalWeb* eHARS	Test forms and *EvalWeb* will be monitored on a regular basis to assess timeliness of delivered results (post-test counseling).

		within 30days?		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
DIS staff will contact individuals, newly confirmed, within two weeks of them receiving contact information for those individuals to ensure receipt of test results.	Ongoing	Have individuals been notified of HIV test results?	Scan Sheets EvalWeb, Linkage to Care Database, STD*MIS (including CDC Forms).	Benchmark assessment of linkage to care data and DIS interview sheets. Ongoing monitoring and review of online linkage tracking database to determine timeliness and completeness of contacts by DIS.

Priority: Need to assure individuals receiving rapid tests receive initial results.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 4: At least 98% of individuals receiving HIV rapid tests in non-clinical settings will receive initial results.		Have individuals receiving rapid tests had initial results?	*EvalWeb*	Test forms and *EvalWeb* will be checked to assess whether individuals who had a rapid test received an initial result.
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
All staff conducting HIV tests are mandated by state statute, to provide the Fundamentals of HIV Prevention and Counseling, as pre/post counseling, to all individuals testing for HIV.	Ongoing	Has staff been appropriately trained to deliver HIV test results?	Training Certificates of Completion	In order for staff to conduct HIV testing, they will be required to show proof of training completion.
Within a 40 minute time frame, State HIV testers will deliver test results to those who have	Ongoing	Have test results been delivered?	*EvalWeb* Test Forms	On the testing form, there is a question asking whether an individual was provided their

received HIV testing.				results or not. The data from EvalWeb can be analyzed to determine the number of individuals that had their test results delivered.

Priority: Individuals receiving rapid tests must receive confirmatory testing and be notified of results.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 5: By 6/30/2013 at least 85% of persons with a reactive test result will receive confirmatory testing. **Objective 5b: By 12/31/2012, at least 85% of persons who test positive for HIV will receive their test results within 30 days.**		Have preliminary reactive tests been confirmed? Number of confirmed HIV+ results?	eHARS	All confirmatory tests must be reported to HIV surveillance per state law. Security and Confidentiality guidelines will be upheld.
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Sub-grantees will use Orasure or blood draws to conduct confirmatory testing for each reactive rapid test within 48hours. Sub-grantees will use confidential testing and implement the tracking and linkage system to locate, inform, counsel, deliver test results, and link newly diagnosed persons to DIS.	07/01/2012 – 06/30/2013	What proportion of reactive rapid tests received a confirmatory test within 48 hours? What proportion of newly diagnosed persons received their results within 7days of confirmed diagnosis? What proportion was linked to DIS and care within 14 days?	*EvalWeb*; Online Linkage to Care Database	Benchmark assessment of confirmatory testing within 48 hours of reactive rapid tests delivery of results within 7days, and linkage to DIS within 14 days of confirmed diagnosis.
Certified HIV Testers will immediately refer those		Have individual with reactive rapid tests been	*EvalWeb*	*EvalWeb* data will be checked frequently to determine the

individuals newly testing reactive through rapid testing to a local health department for confirmatory testing.		referred to a local health department?		percentage of reactive rapid tests that were referred to a local health department.
Certified testers will use a tracking system to ensure that those newly testing reactive for HIV have indeed been connected to a local health department for confirmatory testing by setting up an appointment for that client.	Ongoing	Has client followed through on health department referral?	*EvalWeb* Tracking System Database	*EvalWeb* data will be analyzed and checked to determine if clients are referred to health departments and if appointments were made.
For those individuals who have not received follow-up or missed their appointment for confirmatory testing, Certified Testers will notify DIS staff to track down clients and get them to the a local health department for confirmatory testing within two weeks of receipt of rapid testing reactive test.	Ongoing	Have DIS been notified of individuals who have not followed through on the referral for confirmatory testing?	Spreadsheets tracked locally	The DIS team will be notified in a timely manner in order to get confirmatory testing completed within 14 days. It will be required/recommended that all initial tests be confidential testing as opposed to anonymous. This will allow the DIS to contact all individuals who have missed their appointments.

Priority: Newly diagnosed individuals must be offered partner counseling services.

	Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
By 12/31/13, at least 90% of persons who receive their HIV-positive test results are referred to Partner Services (within 7 days of having received a positive test result).	Have partner services been offered?	*EvalWeb* eHARS STD*MIS – Data	There will be audits of DIS activity: Pouch, field investigations, interviews, and

Objective 6b: By 12/31/13 assure that 85% of persons who receive their HIV-positive test results are interviewed within 30 days of receiving a confirmed positive result.			Management System Report – Case management Other – Interview records	case management. DIS and Regional Output; Indicators.
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Staff at HIV testing sites will offer partner services, explaining benefits and reassuring confidentiality of the services.	Ongoing	Have services been offered?	*EvalWeb*	Periodically data will be analyzed to assess the percentage of newly diagnosed persons offered partner services within 30 days. This data will help in determining if this objective will be met.
At least 75% of newly diagnosed persons offered partner services will be linked into partner services.	Ongoing	Have newly diagnosed patients accepted partner services?	*EvalWeb*	The database will be checked to assess the number of clients that were linked into partner services.
By 9/30/2013, obtain an HIV contact index of 1.5.				

Priority: Individuals who are newly diagnosed should accept HIV partner counseling services.			
	Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
By 9/30/13, obtain an HIV contact index of 1.5	Has contact index accomplished 1.5 index?	STD*MIS – Data Management System Report – Case	Audits of DIS Activity: Interview, Case management, and DIS and Regional Output Indicators

		management Report Other: CDC forms – field Records, Interview Records, Re-interview records, cluster records	

Priority: Partners of newly-diagnosed HIV-positive individuals should be notified of their need for HIV testing.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 8a: By 6/30/2013, assure that 58% of newly identified partners are notified of exposure. **Objective 8b: By 6/30/2012, assure that 79% are notified within 14 days.**		Have partners been notified of need for HIV testing?	STD*MIS – Data Management System Report – Case management Report Other: CDC forms – field Records, Interview Records, Re-interview records, cluster records	Audits of DIS activity: Pouch, Field Investigations, Case management, DIS and Regional Output Indicators
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
DIS staff will notify 80% of elicited partners within 14 days	Ongoing	What proportion of elicited partners is contacted within 14 days?	STD*MIS – Data Management System Report – Case management	Bench mark assessment of proportion of partners being notified.

			Report Other: CDC forms – field Records, Interview Records, Re-interview records, cluster records	

Priority: Highest risk individuals must have access to condoms.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 9a: By 12/31/2013, at least 100,000 condoms will be purchased and distributed to clinical and non-clinical partners. **Objective 9b: Increase condom availability and accessibility by 75% within high risk populations by December 31, 2014.** **Objective 9c: To educate and increase knowledge and skills around condom acceptance and use by 75% use among high risk populations by**		Have condoms been purchased? What is the total number of condoms purchased? Total number of condoms distributed (overall). How many condoms were distributed to each target population (MSM, IDU, HR-HET, Other/Unknown, AA, Hisp.) within non-clinical settings stratified by high risk populations?	Invoices Condom tracking sheet and EvaluationWeb Pre/post tests n condom use skills Outcome monitoring surveys/interviews	Invoices and financial worksheets will be maintained to track purchasing of condoms.
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Health department to obtain and distribute community-accepted	Ongoing through	How many condoms been distributed to each	Site Information Worksheets;	Health Departments will be asked to keep track and monitor

brands of condoms.	06/30/2013	community agency/site?	Condom Distribution Log	the distribution of condoms to community agencies. Reports will be sent to KDPH.
Contracted agencies to identify new and appropriate venues for condom distribution.	Ongoing through 06/30/2013	How many new venues have been identified for condom distribution?	Site Information Worksheets	Health Departments will be asked to keep track and monitor the distribution of condoms to community agencies. Reports will be sent to KDPH.
Contracted agencies to distribute condoms in appropriate venues.	Ongoing through 06/30/2013	How many condoms are being distributed at each venue?	Site Information Worksheets; Condom Distribution Log	Contracted agencies will be asked to keep track and monitor the distribution of condoms to community agencies. Reports will be sent to KDPH.
Health department to obtain and distribute condoms to clinical service providers for 'brown bag campaign.'	Ongoing through 06/30/2013	How many condoms have been distributed to each clinical service provider?	Site Information Worksheets; Condom Distribution Log	Health Departments will be asked to keep track and monitor the distribution of condoms to community agencies. Reports will be sent to KDPH.
Increase condom distribution by 5,000 to non-clinical venues, during HIV Partner Services, during HIV CTR and to all ASO's; (clinics serving HIV+ persons) Identify new and appropriate venues for condom distribution and schedule regular distribution times; (i.e., barber shops, nail salons, community laundry facilities and other local businesses). Provide technical assistance to CBOs on identifying cost-effective ways to purchase condoms in bulk	By 12/31/2013	In how many newly identified venues are condoms being distributed? Are these sites distributing condoms? Are people picking up condoms from these sites? How many agencies are purchasing their own condoms in bulk.	EvaluationWeb Condom Distribution Log	

and minimize cost of delivery/distribution		Are condom delivery times at each venue consistent?		

Priority: Organizations distributing condoms should have strategies in place to target high risk individuals.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 10: By 9/30/2013, technical assistance on distribution strategies to reach highest risk populations will be provided to at least ten clinical and non-clinical partners.		Has technical assistance been provided to community agencies?	Online Databases	Online Databases will be implemented and employed to keep track of technical assistance (TA) requests and completed TA trainings.
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Contracted Local Health Departments, contracted community-based organizations, and contracted non-traditional partners will receive Technical Assistance, during Grantee Orientations, around the specific zip codes and areas, as well as venues to target high risk individuals for targeted condom distribution.	7/30/2012	Has technical assistance been provided?	Online Databases	Online Databases will be implemented and employed to keep track of technical assistance (TA) requests and completed TA trainings. The databases will be checked periodically.
Health Department will provide technical assistance to CBOs on identifying cost-effective ways to purchase condoms in bulk and	Ongoing	How many agencies are purchasing condoms in bulk?	Invoices; Vendor Interviews	In addition to conversations with vendors, invoices and financial worksheets will be maintained to track purchasing of condoms.

minimize cost of delivery/distribution.				
Conduct safer sex gatherings that will educate high risk populations and that will promote safer sex. Conduct group level informational sessions on safer sex. Outreach workers to distribute role model stories within the target populations/high risk communities that educates on proper condoms use and purpose of condom use.	By December 31, 2013	What is the total number of safer sex gatherings? Number of target population members who participated in safe sex gatherings? Number of participants who walk away with condoms? Number of informational sessions conducted. Number of target population members who attended sessions.		Conduct pre/post tests on condom use/skills. Conduct initial & follow-up Outcome monitoring interview/surveys.

KDPH will continue to monitor distribution strategies, and make amendments and updates to distribution strategies, and offer ongoing technical strategies to local agencies and community-based organizations.	Ongoing	Has monitoring and feedback on condom distribution been provided?	Online Databases	Online Databases will be implemented and employed to keep track of monitoring and feedback. These databases will be checked periodically.
Health Department will strategize ways to distribute condoms to high risk populations via social media channels.	Ongoing	How many individuals are accessing condoms via the social media channels (i.e. how many hits does the condom website receive;	Online Hit Counter or Analytics Report from Website	Online hit counter or Analytic Reports will be assessed on a monthly basis to determine effectiveness of social media push.

Strategize ways to distribute condoms to high risk populations via social media channels.	June 30, 2013	how many texts/tweets are sent; etc.)? How many individuals are accessing condoms, education and supportive services via the social media channels? How many hits does the website and other social media channels have?		

Priority: Persons living with HIV having difficulty changing behavior need HIV prevention interventions.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 12: By 9/30/2013, at least 200 individuals living with HIV will successfully complete group level interventions. **Objective; By 12/31/2012, atleast 100,000 condoms will be distributed**		Have HIV-positive individuals participated in prevention interventions?	Online Databases	The database will be regularly monitored to assess the number of clients that completed prevention interventions.
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Contracts with prevention organizations will be executed specifying terms of positive prevention delivery.	07/01/2012	How many contracts been executed?	Signed Contracts	Grant Administrator oversees delivery of services to ensure terms are being met.
Staff will be trained in selected interventions.	Ongoing	How many staff been trained?	TRAIN Certificates of Training Completion; TA provided by CBA providers, NASTAD and	Verified through State HD coordinated site visits and evaluations received through trainings, as well as information provided in quarterly trainings.

			State HD Staff	
Conduct prevention interventions and distribute condoms.	07/01/2012 - 06/30/2013	How many interventions were conducted at each site? How many condoms were distributed at each intervention at each site? Number of venue sessions conducted. Types of venues where condoms distributed.	Number of attendees counted by staff. Number of condoms distributed as counted by staff.	Conduct follow-up outcome monitoring interview/survey.
At least 120 clients in Louisville will complete positive prevention interventions.	07/01/2012 – 06/30/2013	How many Louisville clients attended/received condoms?	Number of attendees counted by staff. Number of condoms distributed as counted by staff.	Using elements of DEBIs to assure QA.
At least 40 clients in Lexington will complete positive prevention interventions.	07/01/2012 – 06/30/2013	How many Lexington clients attended/received condoms?	Number of attendees counted by staff. Number of condoms distributed as counted by staff.	Using elements of DEBIs to assure QA.
At least 40 clients in Northern Kentucky will complete positive prevention interventions.	07/01/2012 – 06/30/2013	How many Northern KY clients attended/received condoms?	Number of attendees counted by staff. Number of condoms distributed as counted by staff.	Using elements of DEBIs to assure QA.
Conduct pre/post tests on condom use/skills for each session of the intervention	07/01/2012 – 06/30/2013	Did the interventions have an impact on the participant's knowledge,	Pre/post tests	Conduct follow-up outcome monitoring interviews/surveys

among each site.		attitude, and skill?		
Reports will be submitted on positive prevention interventions.	07/01/2012 – 06/30/2013	Have timely reports been submitted?	Submitted Reports	Reports will be required on a monthly basis and monitored by CHFS Prevention Team.
Prevention Program staff will monitor progress on goals, providing TA and support as indicated.	07/01/2012 – 06/30/2013	Have reports been monitored and feedback/TA provided?	Monitoring Reports	Prevention Team will assess monthly submitted reports, identify support/TA needs and follow-up with necessary trainings in a timely manner.

Priority: Change in community norms to support HIV prevention activity is needed.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 13: By 6/30/2013, conduct advocacy efforts around changing social norms.				
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Identify social norms through series of focus groups and surveys.	Ongoing	How many focus groups were conducted? How many participants at each focus group? How many surveys were collected?	Focus Group feedback and Survey Responses	Sign in sheets at each focus group; review of surveys by Part B and prevention program staff.
Conduct social marketing/advocacy in high risk communities around condom use.	Ongoing	How many condom packets were distributed? How many PR spots, billboards, etc. within target sites?	Condom Distribution Log	Health Departments will be asked to keep track and monitor the distribution of condoms to community agencies. Reports will be sent to KDPH.
Identify key stakeholders and ascertain their "buy-in" (i.e. faith based communities,	Ongoing	How many stakeholders identified? How many focus groups conducted? How	Site Information Worksheets; Survey Responses	Through community assessment and conversations with vendors.

gatekeepers, CSW, politicians, etc.)		many surveys collected? How many interviews conducted?		
Conduct monthly "open space" sessions to address various STD's (including HIV). These sessions would offer education to parents, guardians, or any interested adult that has influence.	Ongoing	How many participants were registered for each session? How many participants actually attended each session?	Number of attendees counted by staff; sign in sheets	As monitored through the State HD coordinators and needs of the community.
Objective 14: By 6/30/2013, social marketing presence on condom distribution will be increased to 3 social media channels.		How many social media channels have been used to market condom distribution?		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Create a social media plan and develop a social media comprehensive strategy.	**09/30/2013**	How many options are within the plan/strategy? Was the plan effective?	Number of hits on websites; sign in sheets at social events	Collaboration of state Prevention and Part B programs to utilize outreach to be most effective.
Utilize online applications such as Facebook, blogs, Twitter and other appropriate applications to market all prevention activities and maintain contact with visitors. Frequently post relevant up-to-date information.	Ongoing	How many hits to website? How many printed materials were distributed with website link?	Website Data Link	Monitoring of website to ensure effect usage
Objective 15: By 6/30/2013, CBA services on developing an effective structural intervention on condom distribution will be provided to 6 CBOs and 8 ASOs.				

Activity	Time Frame	Monitoring/Evaluation Question	Data Source	Quality Assurance Plan
Develop training on structural interventions with focus on condom distribution: two-fold: TOF and Participant trainings. Develop a facilitator's manual as well as a participant's manual.	**09/30/2013**	Do the CBOs/ASOs find the training helpful?	Pre/post tests	**Comparison of pre and posttests; monitor improvements and deficiencies. Make changes as necessary**
Conduct an interactive training on structural interventions focusing on condom distribution (i.e. role plays, teach backs, group case studies, etc.)	**09/30/2013**	How many trainings are conducted? How many CBO/ASO staff are trained at each of the trainings?	Sign in sheets	**Group survey at end of training**
Conduct trainings for the trainer within the CBOs/ASOs.		How many trainings are conducted? How many TOF received training? How many completed the training?	Attendance sheets, attendance records	**Follow up with attendees; material survey of training**
Evaluate trainings with a pre and post-test survey to measure the effectiveness of the training.		How many surveys were distributed and completed? What percentage of participants reported an increase in knowledge as a result of the training?	Pre-Post surveys	**Surveys from participants at end of training; feedback from both participants and trainers**
Objective 16: By 6/30/2013, at least three contracted entities will implement Safe in the City—a community level HIV prevention intervention.		Have contract agencies implemented Safe in the City? How many persons viewed the Safe in the City while in the Waiting Room(s)?	DVD of Safe in the City	Using elements of DEBIs to assure QA.

Activity	Time Frame	Monitoring/Evaluation Question	Data Source	Quality Assurance Plan
Prevention contracts will be executed outlining terms of community-level intervention delivery.	09/30/2012	Have contracts been executed?	Signed Contracts	Grant Administrator oversees delivery of services to ensure terms are being met.
Staff will be trained in implementing Safe in the City.	12/31/2013	Has staff been trained in implementing the intervention?	TRAIN Certificates of Completion	Verified through State HD coordinated site visits and evaluations received through trainings, as well as information provided in quarterly trainings.
Louisville Metro STD Clinic will Implement Safe in the City in their waiting room as a community level intervention.	Ongoing	Is Safe in the City being implemented in waiting room?	Video/timesheets	Timesheets stating when video was turned on and for how long can be used to determine whether the intervention is being implemented in the specific clinics.
Lexington-Fayette County Health Department will Implement Safe in the City in their waiting room as a community level intervention.	Ongoing	Is Safe in the City being implemented in waiting room?	Video/timesheets	Timesheets stating when video was turned on and for how long can be used to determine whether the intervention is being implemented in the specific clinics.
Northern Kentucky Independent Health Department will Implement Safe in the City in their waiting room as a community level intervention.	Ongoing	Is Safe in the City being implemented in waiting room?	Video/timesheets	Timesheets stating when video was turned on and for how long can be used to determine whether the intervention is being implemented in the specific clinics.
Funded agencies will track implementation of Safe in the City and report to the health	Ongoing	Are agencies tracking progress on implementation?	Progress Reports	Grant Administrator oversees delivery of services to ensure terms are being met

department progress toward 6programmatic goals.				
Prevention staff will monitor reports, provide feedback, and develop capacity-building plans as indicated.	Ongoing	Has progress been monitored and TA needs addressed?	Monitoring Reports Online Databases	Grant Administrator oversees delivery of services to ensure terms are being met

GOAL 2: INCREASE ACCESS TO HIV CARE SERVICES AND IMPROVE HEALTH OUTCOMES. REDUCE NEW INFECTIONS IN HIGHEST INCIDENCE AREAS.

Priority: Individual should be linked to HIV care and treatment following confirmatory HIV testing.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective: By 12/30/2013, increase the proportion of reactive HIV tests receiving a confirmed Western Blot by **Objective: By 12/30/2013, at least 80% of newly identified HIV positive individuals will make their first medical appointment within 3 months of diagnosis.** **Objective: By 12/30/ 2015, increase the proportion of newly diagnosed patients linked to clinical care within three months of their HIV diagnosis by 15%.**		Have HIV-positive individuals made/kept initial appointments? Number of persons who attended a routine HIV medical care visit within 3 months of HIV diagnosis. Number of HIV diagnosed clients who participated in a program or activity designed to link them to HIV medical care.	Online Linkage to Care tracking database Evaluationweb CareWare eHARS Tracking Databases	As monitored through the State HD coordinators.
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Provide linkage to HIV care, treatment, and prevention services for those persons testing HIV-positive or currently living with HIV/AIDS. Work with newly established HIV DIS to ensure linkage to care in Jefferson County and	01/01/2013	Are DIS in Jefferson County improving linkages to care from testing and counseling sites?	STD is unaware of any data sources	As monitored through the State HD coordinators and based off the needs of our contracted agencies.

Fayette County. Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.		Number of persons in Jefferson County and Fayette County who attended a routine HIV medical care visit within 3 months of HIV diagnosis. Number of Ryan White Part B client s being referred and linked to medical and social services?		
Offer referral and linkage to other medical and social services such as mental health, substance abuse, housing, safety/domestic violence, corrections, legal protections, income generation, and other services as needed for HIV-positive persons.				
Train staff from at least six CBOs in ARTAS.	12/31/ 2013	Has staff been trained in ARTAS?	Training registration sheets [QN] Sign in sheets[QN]	Registration/sign in sheets will be collected to assess the number of staff who was trained in ARTAS and what CBO they belonged to.
Priority: Continue providing high-quality HIV core medical services in all Part B clinical settings.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective: By 9/30/2013, the Grantee will assure that all Part B core medical services are being conducted in accordance with current treatment guidelines. **Objective: By 12/30/2015, Increase the**		Are core medical services following appropriate standards? Number of persons with an	CareWare; eHARS, Part B internal accounting system	Comprehensive site visits to contractors at least bi-annually by Care Coordination Administrator and annually by Grant Administrator.

proportion of persons in HIV medical care who are on Antiretroviral Therapy (ART) by 5%. **Objective: By 12/30/2015, increase Viral Load Suppression Among Persons in HIV Medical Care by at least 10%.**		HIV diagnosis and who had at least one HIV medical care visit in the 12-month measurement period. Number of persons with an HIV diagnosis who are prescribed ART in the 12-month measurement period. Number of HIV diagnosed clients who participated in a program or activity designed to increase adherence to ART Number of persons with an HIV diagnosis with a viral load <200 copies/mL at last test in the 12–month measurement period.		Support reporting of CD4 and viral load results to health departments and use of these data for estimating linkage and retention in care, quality of care, and providing feedback of results to providers and patients, as deemed appropriate.
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
All medical care delivered in Part B settings will be in compliance with PHS Guidelines.	Ongoing	Are PHS Guidelines being followed?	CareWare PHS Guidelines	All staff will become aware of the PHS guidelines; QA will be measured during compliance site visits performed bi-annually.
All Part B medical service providers will provide ART administration in compliance with current treatment.	Ongoing	Are treatment providers following treatment guidelines?	CareWare ART Guidelines	All staff will become aware of the ART guidelines; ART will be incorporated into CQM and technical assistance will be provided to sub-grantees.
95% of individuals referred to	01/01/2013	Are KADAP new clients	KADAP Portal	Data from the KADAP Portal

KADAP office will be enrolled as clients within five days of receipt of referral.		enrolled within five days?		will be analyzed to assess the time it takes for clients to be enrolled.
Remove current cost containment measures to enhance access to additional medications for Part B clients.	06/30/2013	Have cost containment measures been eliminated?	KADAP protocol review [QN]	Supplemental and Emergency Relief Funding have been applied for to reinforce current trend of enrollment and remove cost containment measures put in place September 2010.
Case management policy and procedures/standards will be revised and distributed to case managers.	Ongoing	Have case management standards been revised? Have Medical Case Managers received technical assistance on updated standards/policy?	HRSA Monitoring Standards and Expectations Guidelines	Medical Case Managers will be provided technical assistance for Care protocol and best practices. State guidelines will be update to align with HRSA monitoring standards.

Priority: Need for monitoring and effective program evaluation in HIV care settings.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 3: By 9/30/2013 Part B program will monitor and provide quality assurance, support, and timely feedback to providers in Part B contracted agencies.		Have all Part B providers received site visits?		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Bi-annual fiscal, KADAP, and program administrative quality assurance visits will be scheduled.	Ongoing	Have QA visits been scheduled?	Monitoring tools	Site visits will be performed by Part B staff to ensure programmatic compliance. Technical assistance will be performed on site and customized based upon needs.

Quarterly case management visits will be conducted.	Ongoing	Have case management visits been conducted?	CareWare	Site visits will be conducted to assure comprehensive medical case management and linkage to care.
Feedback will be provided to program staff on successes and improvement opportunities.	Ongoing	Has feedback to contract agencies been provided?	Monitoring Tools	Feedback will be provided during and subsequently after trainings and site visits.
Quality Management Task force to maintain monthly phone conferences and bi-annual in-person meetings.	Monthly/Bi-Annually	Is QM Task Force convening as planned?	Sign In Sheets Meeting Agendas	One representative from each contracted facility will be on Quality Management Task Force mandated in request for proposal.
Part B Program to implement Care Ware data collection to enhance program monitoring capacity.	August 2012	Has Care Ware been implemented?	RW CAREWare Client Database	State server space has been reserved for CareWare Data migrated from each contracted agency; data will utilized from all contractors and state contracted pharmacy.

Priority: Foster mechanisms in care settings which promote medication adherence and enhance retention in care.			
	Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 4b: By 12/30/2015 increase the proportion of Part B clients retained in care by at least 10%.	Number of persons with an HIV diagnosis who had at least one HIV medical care visit in each 6 month period of the 24 month measurement period, with a minimum of 60 days between the first medical visit in the prior 6 month period and the last medical visit in the subsequent 6 month period	CAREWare eHARS	

		Has retention in care settings improved? Number of HIV diagnosed clients who participated in a program or activity designed to retain or reengage them in HIV medical care.		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
During quarterly training sessions, medical case managers will be trained and supported in assisting with retention in care and medication adherence.	Ongoing beginning Sept. 2012	Have case management trainings included content on retention and medication adherence?	Training Materials Technical Assistance	Subject matter experts will be brought into quarterly trainings for provide technical assistance in continual improvement in retention in care and medication adherence.
HIV funded DIS will assist with locating and encouraging return to care of consumers who have missed appointments/lab work.	Ongoing	Have DIS assisted in linking individuals out of care back to care services?	Shared Data Tracking Sheet	Collaborations of CBO's and LHD with DIS and case management to get client back into care.
Enhance KADAP tracking system to identify 92% of patients who are 'not in care' and notify case managers and patients.	Ongoing	Has KADAP tracking helped with identification of individuals not in care?	KADAP Portal	Client, medical case manager and pharmacy will be notified in writing of those clients who did not recertify two times per year, during birth month and six months after.
Support development of peer-to-peer programs in care settings to enhance retention and medication adherence.	Ongoing	Have peer-to-peer programs begun which are focused on retention and adherence?	Peer to Peer Program Materials	Technical assistance and program materials will be provided for experienced clients to assist those naïve clients to navigate through the

				systems of care.

Priority: HIV positive persons with unmet need (i.e. who are aware of their HIV status but have not received Primary HIV medical care in the previous 12 months) should be identified, tracked and linked to care to reduce HIV disparities and poor health outcomes				
Objective: By 2015, increase the proportion of Ryan White Part B Program clients who are in continuous care (at least 2 visits for routine HIV medical care in 12 months at least 3 months apart) by 10%. **Objective 9a: By 6/30/2013, at least 80% of persons in Louisville, Lexington and Northern KY regions identified as having unmet need will be referred to DIS for identification and tracking.** **Objective 9b: By 6/30/2014, DIS will conduct tracking activities for at least 70% of those identified in Louisville, Lexington and Northern KY regions as having unmet need .** **Objective 9c: By 6/30/2015: DIS will locate and link to care at least 40% of unmet need**	12/31/2015	Number of Part B clients with at least 2 routine visits (separated by 3 months or more) for HIV medical care in the 12 month measurement period. Number of HIV positive persons with unmet need, identified and linked to care.	STD*MIS EvaluationWeb Online linkage tracking database	

persons in Louisville, Lexington and Northern KY who are locatable.				
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Surveillance staff will complete the unmet need estimate for Louisville, Lexington and Northern KY and provide individual level data and information on trends to DIS on an annual basis. DIS will use proven strategies and tools to track and locate persons with unmet need in the stated regions, with priority given to demographics (by race, ethnicity, age, gender, and risk factor) that are most impacted by unmet need. DIS will contact and make an appointment for persons with unmet need who are locatable with their regional care coordination (Ryan White Part B services). Regional Ryan White Part B Services will make the first HIV primary medical appointment for	10-01-2012 – 06/30/2015 01/01/2013 – 06/30/2014 01/01/2013 – 06/30/2015 01/01/2013 – 06/30/2015	Unmet need data analysis completed for Louisville, Lexington and Northern KY identified and provided to DIS? What proportion of persons with unmet need were identified and successfully located in Louisville, Lexington and Northern KY? What proportion of identified persons with unmet need made their first appointment to the regional Ryan White Part B care coordination services? What proportion of identified persons with unmet need made their first appointment	eHARS, CAREWare, EvalWeb, STD*MIS, Medicaid, Medicare Database, TB Database, Regional Hospital Databases, Database of key regional private physicians. Online Google Doc for unmet need	Annual data matching of all listed databases. Benchmark analysis of unmet need data to determine completeness and cleanliness. Training and technical assistance for DIS in proven strategies and best practices for locating PLWH with unmet need. Identification and utilization of best practices and tools.

all located persons with unmet need and enroll those persons who are eligible into care coordination services.		to HIV primary medical care?		

Priority: Capacity-development in HIV care settings.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 5: By 9/30/2013 at least 30 trainings targeting HIV care providers.		Have trainings been conducted for HIV care providers?	TRAIN Sign-in Sheets	Statewide Provider Conference and collaboration; Clinical Quality Management Site Visits by Part B staff.
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Collaborate with Part F grantee on recruitment of participants including nurses, mid-level providers, and physicians to select trainings.	9/30/2012	Have participants been recruited into AETC-sponsored trainings?	TRAIN	Collaborate with dental facilities such as the UL School of Dentistry; representatives on KY HIV Planning and Advisory Council.
Provide technical assistance and follow up as indicated.	Ongoing	Has TA been provided?	Sign In Sheets	New Contractor orientation customized technical assistance during compliance site visits and quarterly trainings for contracted staff and ongoing Part B staff training and technical assistance.
Quarterly case management trainings to be scheduled to address identified capacity-building needs of medical case managers.	09/01/2012	Have quarterly CM trainings been conducted?	TRAIN Sign-in Sheets Completion of Training Certificates	Technical assistance to be provided quarterly by KHCCP Administrator and other subject matter experts and as needed.
Staff in Part B program office will receive ongoing training on	Ongoing	Has Part B staff participated in training/professional	TRAIN Sign-in Sheets	HRSA trained consultants have been contracted to provide

HIV care, retention, adherence, and Part B program requirements.		development activities?	Completion of Training Certificates	technical assistance to internal Part B staff in retention in care, medication adherence and Part B program monitoring standards.

Priority: Need to assure providers and patients remain aware of changes associated with health reform and Ryan White re-authorization.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 6: By 9/30/13 all Part B consumers and Part B care providers will be informed of changes associated with ACA and reauthorization of the Ryan White Treatment and Modernization Act.		Have stakeholders been informed of changes associated with ACA and the Ryan White programs?	ACA	All staff will be familiar with ACA and the RW Treatment and Modernization Act. Any changes made to these documents will be forwarded to stakeholders.
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Part B staff will monitor changes associated with the Affordable Care Act and inform stakeholders of associated changes to Part B program.	Ongoing	Are changes associated with ACA monitored and reported to stakeholders?	ACA	All staff will be familiar with ACA and the RW Treatment and Modernization Act. Any changes made to these documents will be forwarded to stakeholders.
Part B staff will monitor changes associated with the reauthorization of Ryan White and inform stakeholders of associated changes within the Part B program.	Ongoing	Are changes associated with Ryan White monitored and reported to stakeholders?	Reauthorization of Ryan White	All staff will be familiar with ACA and the RW Treatment and Modernization Act. Any changes made to these documents will be forwarded to stakeholders.

GOAL 3: REDUCE HEALTH DISPARITIES AMONG AFFECTED SUBPOPULATIONS.

Priority: Racial and ethnic minorities are underutilizing HIV testing services.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 1: By 9/30/2013 ten non-traditional HIV service providers will perform at least 200 HIV tests among racial and ethnic populations.		Have HIV tests been performed by non-traditional providers?		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Contracts with non-traditional providers will be executed.	9/30/2012	Have contracts been executed?	Number of responses to Request for Proposals	Capacity building of respondents.
Training and technical assistance with non-traditional partners will be conducted.	1/31/2013	Has training and TA been conducted?	Reports from consultant providing the training	Capacity of fulfillment of contract and follow up with non-traditional partners.
Funded agencies will receive HIV rapid tests.	9/30/2013	Have tests been ordered/ received in funded agencies?	Number of tests distributed	Data compiled by testers and number of tests provided

Priority: Ongoing need for HIV testing among MSM exists.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 2: By 9/30/2013 at least 4,000 HIV tests will be performed for MSM by contracted agencies.		How many tests have been performed for MSM?		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Contracts with prevention agencies will be executed.	07/01/2012	Have contracts been executed?	Executed contracts by 7/01/2012	Review of agencies for assurance of capacity to perform scope of work

Test supplies will be ordered.	06/01/2012	Have test supplies been ordered/delivered?	Verification of number of tests delivered	Tests to be paid for with Prevention funding
HIV tests to be conducted	Ongoing	Have test been conducted?	Data Share tracking sheet	Verification of tests used and data compilation
Consumers will be notified of their HIV test results.	Ongoing	Have results been conveyed to consumers? of stories developed on safer sex practice. # of stories distributed. # of people reached. # of times distributed within a week (frequency). # of condom packets distributed	Tracking of posttest counseling by identified consumers	All identified consumers will be posttest counseled and referred to Part B case management for linkage to care.

Priority: Access to HIV care in rural Kentucky is difficult.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 3: By 9/30/2013 improve access to services for 150 rural Kentuckians by reducing distance to HIV care to less than one hour.		Have new service providers been identified for HIV + consumers in rural KY?		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Work with local case management and program administration staffs to identify patients with long commutes to care settings.	Ongoing	Have regions with long commutes to care been identified?	CareWare and Part B contractors	Continual review of consumers with commutes in excess of 30 minutes; recruitment of specialty care providers.
Provide support to local staff to advocate among medical providers in local areas to	Ongoing	Has local staff been given support to advocate to medical providers in their	Contact with local staff	Communication and site visits by Part B staff for TA and input

provide care to Part B patients.		region?		
Provide support to clinics considering satellite services in regions with more challenging access issues.	Ongoing	Has support been offered to Part B clinical providers in setting up satellite locations for individuals with difficulty accessing care sites?	Contact with contractors	Evaluation of satellite services in rural areas of Kentucky

GOAL 4: ENHANCE COLLABORATIONS TO PROMOTE ACCESS AND HIGH-QUALITY PREVENTION AND CARE SERVICES.

Priority: Need to maintain access to HIV care as health reform continues.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 1a: By 9/30/2013 maintain collaborations with key collaborators to ensure access to HIV care for Part B consumers. **Objective 1b: By 12/31/2014 increase the number and diversity of available providers of clinical care and related services for people living with HIV by 5%.**		Have key collaborations been maintained?		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Monitor changes associated with the ACA and re-authorization of the Ryan White Treatment and Modernization Act and inform stakeholders of implications for Part B providers.	Ongoing	Have changes in HIV care been conveyed to stakeholders?	Quarterly training of contractors and Part B staff	Site visits to evaluate need and technical assistance of identified need by Part B staff, webinars

Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV				
Work with Kentucky Primary Care Association to forge partnerships with key community health centers in KY to assure access to primary care and HIV care for Part B consumers.	Ongoing	Has collaboration with KPCA resulted in enhanced linkages for Part B patients to care in community health centers?	Collaboration with contractors and monitoring KPCA memberships	Data compilation and quarterly review of trend analyses; quarterly technical assistance to contractors by Part B staff
Work with the Kentucky Medicaid Office and Kentucky Department of Insurance to assure seamless health care coverage for Part B consumers and to assist Part B providers with necessary support to transition.	Ongoing	Have collaborations with payers assisted Part B providers in enhancing systems of care.	Collaboration with contractors, Medicaid providers and KHPAC	Quarterly monitoring of consumers who have Medicaid and those who have received Medicaid by Part B staff

Priority: Need to continue internal program collaboration and service integration.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 2: By 9/30/2013, at least one new collaborative effort with STD, TB, and Viral Hepatitis offices.		Have collaborative efforts within the Health Department been successful?		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Continue collaborating with STD with integration of new HIV DIS in Jefferson County.	9/30/2013	How will collaboration and intervention be tracked and measured?	Data Share Tracking Sheet	Consistent monitoring of tracking sheet and ongoing collaboration with CBOs and

				LHDs

Priority: Policy changes need to be made to facilitate a climate for success in HIV prevention.			
Objective 2: By 12/30/15, KHPAC will work with the HIV/AIDS Branch and the Kentucky Department of Education (KDE) to develop and implement a policy for incorporating comprehensive sexual health education in school settings, particularly for 8th graders and a requirement for annual reporting to the state by schools regarding which classes have incorporated comprehensive sexual education as contained in the Kentucky Core Academic Standards and the types of resources being used.			Bench mark assessment of implementation of various components of the policy
KHPAC will work with the Kentucky Department of Education and the HIV/AIDS Branch to assist schools in developing initiatives that build parental knowledge and skills and facilitate effective parent-child discussions around sexual health			Bench mark assessment of implementation of various components of the policy
KDPH will continue to propose mandatory testing of pregnant women. A bill revising KRS214.160 to mandate HIV testing of pregnant women in Kentucky was proposed by KDPH to be included in the Cabinet's 2008, 2009 and 2012 gubernatorial packet of favored legislation. The bill aims to	Has policy for testing of pregnant women been enacted?		Bench mark assessment of implementation of various components of the policy

include HIV in the battery of tests mandated for all pregnant women and follows the recommendations of the 2006 routine testing guidelines as it pertains to testing of pregnant women, including re-offering testing in the 3rd trimester. 902 KAR 2:020 section 7 pertains to HIV testing and what information is to be reported to the HIV surveillance section. As written, it requires that all laboratories send CD4 results and detectable viral loads. Currently, revisions are being made to this regulation to require all viral loads to be reported to the HIV surveillance section. This revision will coincide with current actual practice, in which the KY HIV surveillance branch routinely receives all viral loads regardless of detectable status.				
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
KHPAC convene meetings with KDE, HIV Branch and other pertinent partners to draft policy. KHPAC and relevant stakeholders and partner with state legislators implement the policy, including reporting requirements and the Parent-child initiative. Support efforts to align structures, policies, and	12/31/2013 12/31/2015	Are all pertinent stakeholders being engaged in the policy development process? Have the policy been drafted? Have collaborative efforts with KDE, KHPAC and KDPH been successful? Have all aspects of the developed policy been implemented?	Have collaborative efforts with KDE, KHPAC and KDPH been successful?	Have collaborative efforts with KDE, KHPAC and KDPH been successful?

regulations in the jurisdiction with optimal HIV prevention, care, and treatment and to create an enabling environment for HIV prevention efforts.				
Priority: Budget allocation.				
		Monitoring/Evaluation Question	**Data Source**	**Quality Assurance Plan**
Objective 2: By 9/30/2013, at least one new collaborative effort with STD, TB, and Viral Hepatitis offices.		Have collaborative efforts within the Health Department been successful?		
Activity	**Time Frame**	**Monitoring/Evaluation Question**	**Data Source**	**Quality Assurance Plan**
Objective: By 12/31/2013, allocate all HIV prevention funding based on geographic disease incidence among high risk populations and geographic impact. **Objective: By 12/31/2013, develop service prioritization and resource allocation tools for Ryan White Part B services to reflect HIV incidence, and needs of persons living with HIV in different geographic areas. Implement tools by 01/01/2014.**	December 2013	Amount of allocations for prevention activities (HIV Testing, Comprehensive Prevention with Positives, Condom Distribution, Policy Initiatives, Prevention Planning, Capacity Building, Monitoring & Evaluation and Other) Amount of allocations for priority activities (HIV testing) stratified by target populations ((MSM, IDU, HR-HET, Other/Unknown, AA, Hisp.) Amount of allocations for priority activities (condom distribution) stratified by target populations (MSM, IDU, HR-HET, Other/Unknown, AA, Hisp.)	Fiscal monitoring database Online fiscal tracking spreadsheet. Monthly fiscal reports from AF&M	Consistent monitoring of tracking sheet and ongoing collaboration with CBOs and LHDs Monthly review of fiscal reports from Administrative Financial and Management (AF&M) Resource allocation and prioritization process with community planning group

Capacity-Building Efforts

Capacity Building efforts are detailed under the "Combined Goals/ Objectives" section of this strategy. The State of Kentucky is committed to meeting the capacity-building needs of its partners. Through an ongoing relationship with CDC-funded Capacity-Building Assistance [CBA] providers, the Prevention Program routinely utilizes the opportunity for internal and external training opportunities. Through the Capacity-Building Branch [CBB] at CDC, the Branch and its partners routinely take advantage of webinar and distance learning opportunities made available.

The Prevention staff closely monitors grantee input in the CRIS system and uses this tool to request and track prevention training needs which can be provided as part of the agreement with CBB.

In addition to the above prevention activities, there are plans to provide capacity-building in a range of "Positive Prevention" interventions. Working with the CBA providers for Kentucky, it is anticipated that training in the ARTAS intervention will be available to a number of grantees by mid-2012.

In terms of capacity-building for Part B care providers, there is an ongoing collaboration with the KY AIDS Education and Training Center, the Part F grantee for the State. Through this collaboration, the Branch is able to provide high-quality clinical training to clinicians and to attempt to meet the needs of case managers and other Part B-funded professionals.

The annual HIV conference is an important opportunity to reach both prevention and care providers in the State. This meeting, reaching between 300 and 500 health care workers has historically been an important opportunity to provide training on current topics and to assure that HIV

medical care updates are available in a timely way to clinicians participating in the conference.

Request for Capacity Building Assistance and technical assistance will be made to CDC to provide training for HIV testing, prevention, and linkage to care for the volunteers recruited by KHPAC.

In addition to formal capacity-building efforts, the commitment to quality improvement offers an important opportunity for informal feedback, coaching, and strategizing to resolve performance challenges. Each care site will be visited at least annually, and prevention grantees are often visited annually though informal support and TA happens often via phone and email.

Quality Improvement Activities

Quality Improvement and Monitoring and Evaluation activities are detailed under the "Combined Goals/ Objectives" section of this strategy. Regarding the KY AIDS Drug Assistance Program [KADAP], there is ongoing weekly collaboration on program and client issues on behalf of KADAP clients with the KADAP pharmacy. Regarding the Insurance Continuation Program, regional sites are required to submit monthly activity reports to the KHICP Administrator. This monthly reporting provides expense and utilization information regarding insurance premiums and policy changes. Additionally, fiscal monitoring is completed to ensure timely and appropriate payments of client's insurance premiums and related activities The KADAP Administrator conducts at least one annual comprehensive site visit and periodic technical assistance visits on targeted issues with the contracted pharmacy. In addition, weekly collaboration on program and client issues exists between KADAP and the pharmacy.

Regarding Service/Care Coordination, each of the six direct service contractor sites submit quarterly reports to the KHCCP Administrator. The reports provide a snapshot of trends in exposure, gender, race, risk factor, number of new clients, and other valuable program data about clients accessing services. Regional sites are required to submit a quality management/assurance report annually to the Direct Services Program Administrator. This report provides specific details and measurable outcomes related to quality management/assurances that sites have accomplished. This report also provides sites and the HIV Branch with information regarding needed improvements and accomplishments. The KHCCP Administrator also conducts quarterly site visits to each site and offers ongoing TA via phone and email.

The KAPAP Administrator conducts annual site visits to each regional care coordination site regarding KADAP and related issues and provides technical assistance as needed. The KADAP Administrator analyzes data collected from monthly utilization invoice and quarterly reports submitted by the Kentucky Clinic Pharmacy. These submissions provide the administrator with monthly expenditures, client regimens, client utilization, and identification of third-party payers. Requiring this data has allowed KADAP to create an electronic client utilization system which tracks Federal and state funding and expenditures. The system is used to managing a current listing of client case managers and providers who treat persons with HIV in Kentucky. IN FY 2008, the contracted pharmacy began submitting an additional report to assist in the completion of the ADAP Quarterly Report.

Monitoring and Evaluation of Coordinated Plans

The Kentucky HIV/AIDS Branch, under the coordination of the state Ryan White Part B Program Office, developed a plan in mid-2010 to conduct an update to the Kentucky SCSN. In preparation, the staff of the Ryan White Part B Program reviewed the HRSA SCSN guidance and the SCSN reports from the states of Florida and Michigan in an effort to identify best practices. Per HRSA guidance, attempts were made in the initial planning process to bring together all relevant stakeholders to collaboratively develop a process. These included HIV care providers, Branch staff, representatives from the Ryan White Parts C, D, and F grantees in the State and individuals living with HIV and AIDS.

Initial internal discussions led to the creation of a draft plan for conducting the SCSN and a shared agreement that the process might be aided by utilizing the skills of an external consultant. James Sacco, a consultant with over 20 year's collaboration with HRSA-funded grantees, agreed to assist the Branch in the execution of the plan that was evolving. Using the information gathered from initial reviews of the SCSN guidance and sample SCSN reports, the Branch worked with the consultant to develop a template and action plan for the process of producing the 2012 Kentucky SCSN report.

The first steps after the initial planning process involved the consultant reviewing all relevant documents and previous needs assessments and creating a list of cross-cutting issues. From this process, the Branch created a structure by which volunteers from all the participating stakeholders could assist in a review of relevant material.

This large group process began with a call in May in which the Branch leadership and the consultant reviewed the guidance on SCSN, offered an overview of the task, and distributed the list of cross-cutting issues and template for smaller groups to form, review assessment materials and identify significant statewide care and prevention issues. Volunteers subsequently populated six working groups: Clinical Care, Care Coordination, Dental, Disenfranchised Populations, Prevention, and Collaborations. Each group had between 4 and 8 volunteers and each had a chair or co-chair to lead the process. A time line was developed and groups began the task of reviewing materials.

A follow-up call was conducted in June which included additional participants recruited by the Branch. These additional participants were updated about the process and assigned to one of the existing working groups. Also in June, an interim call was held with group co-chairs to invite additional input and gauge the progress of the working groups. This call advised a slight

revision to the timetable and Branch staff as the consultant stepped down from the project leaving only a list of technical advice. In mid- June, the groups subsequently submitted reports which included identified service gaps, unmet needs, and other relevant issues related to their assigned topics, as well as proposed strategies for addressing some of the issues.

Because of the critical importance of information regarding access to treatment and care, additional input from clinical care providers was sought. Working collaboratively with the Part C AETC local performance site at the University of Kentucky, additional response to issues related to unmet needs and challenges in the clinical care arena were identified by additional HIV clinicians. These unmet needs were incorporated into the existing document, which was merged with additional materials to become a draft SCSN. The Branch staff, compiled group reports into a draft of the 2012 Statewide Coordinated Statement of Need. This document was sent for review by all participants and a follow up call to refine content was held.

The Branch also convened a meeting of representatives from the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC). This advisory/planning body oversees statewide community prevention and care planning activities, and provides legislative advisory as well. In addition, members of the SCSN working groups and affiliated stakeholders were invited to attend. Approximately 30 individuals attended this meeting and an additional six persons participated via conference call. This group represented Branch staff, persons living with HIV/AIDS, dental and medical care providers, HOPWA grantees, SAMSHA grantees, correctional facilities, local and county health departments, Ryan White Part B, C, D and F grantees and sub-grantees, AIDS service organizations, the Department of Corrections, the Department of Education, the state Communicable Disease branch, and HIV prevention staff from throughout the State.

The meeting offered the Branch valuable feedback on the working draft of the SCSN and also advised them on priority problem areas. The group divided into smaller groups that were tasked with prioritizing unmet needs and offering a list of potential solutions. The groups worked efficiently and very effectively and by the end of the day, the goals of the Branch were met. The work yielded very helpful feedback on the SCSN, a list of priority problems to be addressed, and a more thorough list of potential solutions to address the unmet needs in Kentucky.

Using this input, the Branch staff revised the 2012 SCSN to reflect the additional input from the meeting. In addition, Branch surveillance and Ryan White Part B staff (with technical assistance from HRSA) began the internal processes of conducting an unmet need estimate and an assessment of service needs, gaps, and barriers to care for persons living with HIV/AIDS who are not in care.

The outcome of the Statewide Coordinated Statement of Need (SCSN) led directly to the process of creating a Statewide Strategic plan, and goals for 2012. Like many other jurisdictions, Kentucky is faced with a significant budget shortfall for FY 2012, and addressing the identified needs in the current economic environment will require resourcefulness beyond standard

allocations and budgeting remedies. Specifically, Kentucky is developing strategies to partner with other entities to assist with addressing the concerns found in the 2012 SCSN.
Kentucky's plan has been aligned with the National HIV/AIDS Strategy. In addition, every attempt has been made to make sure that the document addresses the priorities established in the *Early Identification of Individuals with HIV/AIDS* [EIIHA] guidance, the *Healthy People 2020* recommendations, and the *Healthy Kentuckians 2020* HIV goals which include finding individuals living with HIV who are unaware of their status, diagnosing them and linking them to care.
The State of Kentucky is committed to reducing rates of HIV infection, providing compassionate, comprehensive care to individuals living with HIV/AIDS, and to combating stigma and health disparities which have fostered a climate where HIV cannot be openly addressed. The jurisdictional comprehensive plan through statewide focus groups, surveys and public meetings which included consumers stakeholders, Kentucky HIV Planning and Advisory Council (KHPAC) and all parts Ryan White, has identified through these processes Kentucky's priority needs. Each priority need was addressed by identified objectives. These objectives have been addressed through performance measures with measurable outcomes through identified data sources and statewide quality assurance plan.

Monitoring

The Kentucky Part B program requires each client to actively engage in the development and participation of an Individualized Care Plan (ICP). The ICP is an assessment of the clients' spectrum of needs and a road map toward HRSA's concept of "self-sufficiency." Every six (6) months, clients are required to conference with a case manager to review the ICP for any changes or updates, and assess the client's progress toward the benchmarks of the ICP. The ICP system has the flexibility to measure success in several ways, including adherence to treatment, barriers to care, and whether a service need has been met. This allows for effective monitoring of clients who may need more intensive case management, and monitoring of adherence and provision of client centered services to each individual client.

- Condom Distribution - This goal is to be implemented by targeting most vulnerable populations and improving access to condoms. Ongoing support for ordering, tracking, monitoring utilization and evaluation of distribution activity will be in place. The focus will be on finding Kentuckians with poor access, providing community accepted brands of condoms, and combining distribution plans with social support for changing norms about condom use.
- Monitoring and Evaluation - The plan for enhanced M & E will include more regular site visits from HIV Program staff.
- At this time, it is important to note that the activities in these goals and objectives will primarily be carried out by the Part B staff. The staff in the Part B office oversees ADAP, Care Planning, Monitoring & Evaluation, and Quality Assurance processes. In

addition, activities which require linkage to care and prevention in HIV care settings will utilize the existing partnerships within the Branch and the Care and Prevention teams.

For KADAP, there are ongoing weekly collaborations on programmatic and client issues on behalf of KADAP clients with the KADAP pharmacy. Regarding the KHICP, regional sites are required to submit monthly activity reports to the KHICP Administrator. The monthly report provides expense and utilization information regarding insurance premiums and policy changes. Additionally, fiscal monitoring is completed to ensure timely and appropriate payments of clients' insurance premiums and related activities. The KADAP Administrator conducts at least one annual comprehensive site visit and some technical assistance site visits focusing on specific issues with the contracted pharmacy. In addition, weekly collaboration on programmatic and client issues exists between KADAP and the pharmacy.

Regarding Direct Services/care coordination, each of the six (6) Direct Services contractor sites submit quarterly reports to the KHCCP Administrator. The quarterly reports provide trends of exposure, gender, race, risk factor, number of new clients entering the program and other valuable data regarding service categories being accessed by clients. Regional sites are required to submit a quality management/assurance report annually to the Direct Services Program Administrator. This report provides specific details and measurable outcomes related to quality management/assurances that regional sites have accomplished. The basis for the report is HRSA's six (6) quality management themes. This report provides regions with a snapshot of areas where improvements need to be made, as well as highlights of accomplishments. Specific emphasis is made on monitoring client accessibility of HRSA's core medical services. The KHCCP Administrator also conducts quarterly site visits to each site and provides ongoing TA via phone and email.

The KADAP Administrator also conducts annual or bi-annual site visits with each of the six (6) regional care coordinator sites regarding KADAP related issues and provides technical assistance as needed.

The Kentucky AIDS Drug Assistance Program (KADAP) Administrator conducts program monitoring by analyzing data collected from a monthly drug utilization invoice and a quarterly Antiretroviral report submitted by the Kentucky Clinic Pharmacy. These submissions provide the administrator with monthly expenditures, client regimens, and identification of third-party payers, client utilization and client's current medical provider, insurance plans and premiums for eligible clients, etc. Requiring this data has allowed KADAP to create an electronic client utilization system which tracks federal and state funding and expenditures. The system is used to maintain a current listing of client case managers and providers who medically treat persons with HIV/AIDS in Kentucky.

In FY2008, the contracted pharmacy began submitting an additional report to assist in the completion of the ADAP Quarterly Report.

If a corrective action is required, written documentation is provided to the contractor outlining the area of concern, and a timeline for corrective action. The contractor and the grantee office collaborate to resolve the area of concern with technical assistance provided by the grantee office where necessary. A document of resolution is provided to all parties at the appropriate time. All corrective actions must be completed within thirty (30) days of written notification. Subsequently, during future site visits, corrective action progress is monitored. In the case of KADAP, the KADAP Administrator notifies the Assistant Director of the contracted pharmacy regarding any fiscal or programmatic concerns. The pharmacy is notified in writing and by phone and must implement a corrective action plan or resolve the issue(s) within 30 days of notification.

Like many other jurisdictions, Kentucky is faced with impending budget shortfalls. The Commonwealth is addressing the identified needs in the current economic environment with resourcefulness beyond standard allocations and budgeting remedies. Specifically, Kentucky is developing strategies to partner with other entities to assist with addressing the concerns found in the 2012 Statewide Coordinated Statement of Need (SCSN). Kentucky's Ryan White Part B Program collaborates closely with the Ryan White partners in the state, many of whom are jointly funded. This includes very close relationships with all four Part C clinics in Kentucky; all are Part B and C recipients. These strategic relationships provide "one stop shops" which provide a comprehensive continuum of care more economically. The State also maintains excellent relationships with both Part F dental reimbursement programs located in Louisville and Lexington. As of 2011, there are two Part D clinics in Kentucky. All of these funded facilities are strategically located across the state for ease of client access to care which removes not only barriers to care but addresses additional care needs for the least funding possible.

The HIV program, in March 2011, began working closely with partners across the State to prepare for changes associated with the Affordable Care Act (ACA). This landmark legislative mandate will allow the number of Kentuckians receiving medical care through Medicaid to grow significantly. Kentucky has recognized that as Medicaid grows, our Ryan White program must adapt and remain flexible for patient access to care. To this end, the Kentucky AIDS Drug Assistance Program (KADAP) began to transition eligible clients from KADAP to insurance assistance; in 2012 this practice will expand. There is an anticipated $5,800.00 per year per client savings in changing KADAP from a Pharmaceutical program to an insurance model. The KADAP program has also applied with Office of Pharmacy Affairs (OPA) to become a rebate state which will open an avenue of program income which will be utilized to provide continuous services and access to care in the event of unanticipated funding cuts either State or Local.

Coordination

This plan has been designed to be aligned with the National HIV/AIDS Strategy. In addition, every attempt has been made to make sure that the document addresses the priorities established in the *Early Identification of Individuals with HIV/AIDS* [EIIHA] guidance, the *Healthy People 2020* recommendations, and the *Healthy Kentuckians 2020* HIV goals which include finding individuals living with HIV who are unaware of their status, diagnosing them and linking them to care.

Kentucky is integrating Healthy People 2020 into the framework of their HIV activities. The goal is for Kentucky to become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity, or socio-economic circumstance, will have unlimited access to high-quality life extending care, free from stigma and discrimination (based on Health People Objective HIV-13). This goal encompasses the four overarching goals of Healthy People 2020 which are:

•Attain high-quality, longer lives free of preventable disease, disability, injury, and premature death;

•Achieve health equity, eliminate disparities, and improve the health of all groups;

•Create social and physical environments that promote good health for all; and

•Promote quality of life, healthy development, and healthy behaviors across all life stages.

To accomplish the goal, objectives and activities have been developed. All seek to improve current targets/baselines. Data was collected and calculated using input from the HIV registry information, CAREWare, Integrated Epidemiologic Profiles, Unmet Need calculations and STD*MIS.

Objective 1: At least 85% of individuals tested for HIV through the state funded public health system will be informed of their test results within three months of testing. In 2010, 82% (263) of the newly diagnosed HIV cases (319) received their test results within three months. The new target is equal to or greater than 85%.

Activities: 1. Increased HIV testing will target High Risk heterosexual African American and Hispanic Women and Gay/Bisexual Men (i.e. groups with high

proportion of individuals unaware of their HIV positive status), within zip codes with the highest HIV prevalence with use of OraSure to conduct field confirmatory testing on same day, onsite for all reactive rapid tests;

2. Develop and implement a seamless enhanced linkage and tracking system between all rapid testing agencies and local health departments providing confirmatory testing, and Ryan White Part B & C supportive Care and medical Treatment agencies in the two regions with combined almost 70% of the total disease prevalence in the state (Louisville and Lexington); and

3. Use Disease Investigation Specialists to follow up on all persons with a reactive rapid test who do not return to receive their confirmed HIV positive results.

Objective 2: At least 75% of adolescents and adults with a newly confirmed HIV-positive diagnosis will be enrolled into care and receive treatment within three months of HIV diagnosis. In 2009, 67% of HIV cases received specified HIV primary medical care (i.e. 33% unmet need- not receiving primary medical care. The target is equal to or great than 75%. (Based on Health People objective HIV-10)

Activities: 1. Disease Intervention Specialists delivering HIV-positive results will link client to HIV Care Navigator (HCN);

2. HCN will enroll client into Ryan White care/services and set up first medical appointment(s);

3. HCN will connect client with Peer Mentor to assist with navigating care system

Objective 3: Increase the proportion of persons surviving more than 5 years after a diagnosis with AIDS to at least 85% (based on Healthy People HIV 11)

1. Improve adherence to and retention in care and treatment through use of peer mentors and HIV Care Navigators (HCN) in region with highest prevalence of HIV (Louisville)to help navigate care system , with particular targeting of minority and men who have sex with men (MSM) cases;

2. Disease Intervention Specialists and HCN follow up on persons who have fallen out of care and try to link them back into care back into care and treatment

Objective 4: Reduce the rate of new HIV infections among adult and adolescent Kentuckians by 10 percent (from 10.9 per 100000 in 2011 to 9.8 per 100000) (Healthy People HIV 4).

Activities: 1. HIV Surveillance will continue to work with reporting labs and providers to ensure timely reporting of HIV infections and subsequent AIDS diagnosis information, Annual evaluations on performance standards are in place;

2. Increase targeted testing efforts to men who have sex with men (MSM) who are unaware of their HIV status, particularly Black and Hispanic MSM in the Jefferson and Fayette Counties as well as MSM in counties within Eastern KY that have a high proportion of HIV cases concurrently diagnosed with AIDS ; and

3. Inform newly infected MSM of their serostatus; provide them with prevention supplies to reduce transmission, offer partner services, and link individuals to care.

Further, this document has been crafted using the *CDC Guidance on HIV Prevention Planning* and the *HRSA SCSN and Comprehensive Plan* guidance. Finally, every attempt has been made to align strategies in this document with the relevant statutes in the *Patient Protection and Affordable Care Act* [PPACA].

Concurrence Acknowledgement

The planning process for this plan has been thorough with participation from multiple stakeholders including consumers, clinicians, administrators, coalition members, representatives of all Ryan White partners in the State, and the Kentucky HIV/AIDS Planning and Advisory Council (KHPAC). The concurrence of the KHPAC with this plan is noted in the attached document.